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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 842

Oct. 13, 1993 Date Issued — Franklin D. Fernandes, Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Louise	Amos	Female	2:00 P M	October 7, 1993

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
316-36-6028	72			August 4, 1921	West Enterprise, Clark City, Mississippi

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No	------	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Margaret Hospital	Hammond	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Willie Amos	Home Maker	

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	935 Eaton Street

13e ZIP CODE	13f INSIDE CITY LIMITS?	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46320	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	Black	5th Grade	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Glenn Earl	Daisy Smith

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Willie Amos	935 Eaton St. Hammond, Indiana 46320	Husband

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	October 12, 1993 Concordia Cemetery	Hammond, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Tracy Cheri Williams	FD08600238	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Tracy Cheri Williams	FD08600238	Hinton-Williams Funeral Home FH830015 4859 Alexander Ave. East Chicago, In.

CAUSE OF DEATH

26 PART I Enter the diseases, injuries, or complications that caused the death Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line

Approximate Interval Between Onset and Death

Immediate cause (Final disease or condition resulting in death):
a. Advanced Metastic Adenocarcinoma
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:

FILED NOV 30 1993

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT (Last 90 DAYS) POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

CERTIFIER

29a CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated

☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated

☐ CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
M Ali MD	29784 (IN)	10.12.93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Mohammed Y. Ali M.D. 9116 Columbia Ave. Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Fernandes M.D.	October 13 1993

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☒ Pending Investigation ☐ Could not be Determined				

34e PLACE OF INJURY—At home, farm, street, factory, office building etc (Specify)	34f LOCATION (Street and Number or Rural Route Number, City or Town, State)

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1