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93-0305

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No: ....   State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First Middle Last): Willa B. Carraway
- 2. SEX: Female
- 3a. TIME OF DEATH: 12:33 AM
- 3c. DATE OF DEATH (Month Day Yr): March 30, 1993
- 4. SOCIAL SECURITY NUMBER: 337-14-6663
- 5a. AGE—Last Birthday (Years): 72
- 5b. UNDER 1 YEAR (Months, Days):
- 5c. UNDER 1 DAY (Hours, Minutes):
- 6. DATE OF BIRTH (Mo Day Yr): January 2, 1921
- 7. BIRTHPLACE (City and State or Foreign Country): Shah, Mississippi
- 8a. WAS DECEDENT A U.S. VETERAN?: No
- 8b. YEAR LAST SERVED IN US ARMED FORCES?: N/A
- 9a. PLACE OF DEATH (Check only one; see instructions): HOSPITAL: XXX Inpatient ☐ ER Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
- 9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
- 9c. CITY, TOWN OR LOCATION OF DEATH: Gary
- 9d. COUNTY OF DEATH: Lake
- 10. MARITAL STATUS (Specify): Married
- 11. SURVIVING SPOUSE (If wife, give maiden name): William B. Carraway
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): School Teacher
- 12b. KIND OF BUSINESS/INDUSTRY: Gary Community School Corp.
- 13a. RESIDENCE—STATE: Indiana
- 13b. COUNTY: Lake
- 13c. CITY, TOWN OR LOCATION: Gary
- 13d. STREET AND NUMBER: 101 Glen Park Avenue
- 13e. ZIP CODE: 46408
- 13f. INSIDE CITY LIMITS: ☐ No XX Yes
- 13g. ON A FARM?: XX No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 15. WAS DECEDENT OF HISPANIC ORIGIN?: XX No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
- 16. RACE—American Indian, Black, White, etc. (Specify): Black
- 17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 6 years

PARENTS

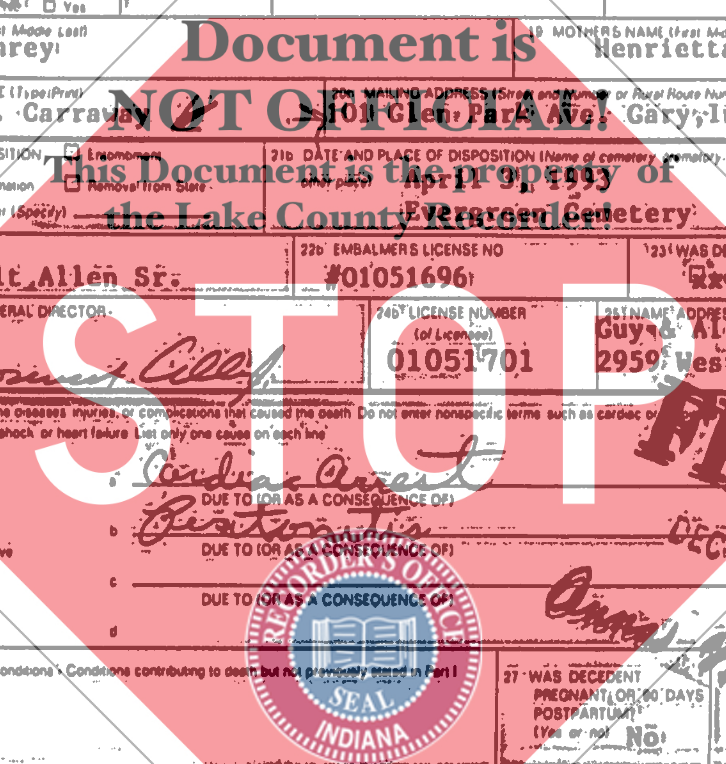
- 18. FATHER'S NAME (First Middle Last): Ed Humphrey
- 19. MOTHER'S NAME (First Middle Maiden Surname): Henrietta Redd

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): William B. Carraway
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 Glen Park Ave. Gary, Indiana 46408
- 20c. Relationship: Husband

DISPOSITION

- 21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): April 3, 1993 Evergreen Cemetery
- 21c. LOCATION—City or Town, State: Hobart, Indiana
- 22a. EMBALMER'S NAME: Roosevelt Allen Sr.
- 22b. EMBALMER'S LICENSE NO: #01051696
- 23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Roosevelt Allen
- 24b. LICENSE NUMBER (of Licensee): 01051701
- 25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 West 11th Avenue Gary, Indiana 46404 — 83007704



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. Cardiac Arrest
  - DUE TO (OR AS A CONSEQUENCE OF): b. Peritonitis
  - 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
- PART II. Other significant conditions. Conditions contributing to death but not resulting in the underlying cause given in Part I:
- 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
- 28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
- 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

FILED DEC 14 1993 — Anna M. Anton

CERTIFIER

- 29a. CERTIFIER (Check only one):
  - XX 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: [signature]
- 29c. MEDICAL LICENSE NO: 5002601
- 29d. DATE SIGNED (Month Day Year): 4-17-93
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): William E. Washington M.D. 1400 Broadway Gary, IN 46407

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: [signature]
- 32. DATE FILED (Month Day Year): APR 19 1993

CORONER USE ONLY

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

6.00

Handwritten in left margin: Key# 46-51-22 Monumental add L. 2 B. 67 — 12/14/93

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

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