5cc \ 94005820

→ George Smith

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 92-0273

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Viola McClain Smith
2. SEX: Female
3a. TIME OF DEATH: 5:13P
3b. DATE OF DEATH (Month, Day, Yr.): April 11, 1992
4. SOCIAL SECURITY NUMBER: 236-54-5567
5a. AGE—Last Birthday (Years): 61
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): SEP 15, 1930
7. BIRTHPLACE (City and State or Foreign Country): Omar, West Virginia
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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): George E. Smith
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): housewife
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 4680 Delaware St.
13e. ZIP CODE: 46409
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Afro Am
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): fred McCain
19. MOTHER'S NAME (First, Middle, Maiden Surname): Viva Owens

INFORMANT

20a. INFORMANT'S NAME (Type/Print): George E. Smith
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4680 Delaware St. Gary, Indiana 46409
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APR 16, 1992 Evergreen Memorial
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee): FD01042607
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell Warner & Son 4209 Grant St., Gary In. 46408

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF):
c. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated 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): No

FILED ... COUNTY ... RECORDER ... 21 3 28 PM '94

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: R H Hovanessian
29c. MEDICAL LICENSE NO.: 01023583
29d. DATE SIGNED (Month, Day, Year): 4/14/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Raffy Hovanession, 7863 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Relius E Foston MD MPH/BC
32. DATE FILED (Month, Day, Year): APR 14 1992

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

FILED

JAN 21 1994

Anna M. Antone
AUDITOR LAKE COUNTY

01237 60

41-216-21 TXS 4680 Delaware Gary I. 46409

Delivery Realty & Inv. Co. att All Lots 20 21 BLK

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE APR 1 4 1992