ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 94020216

CERTIFICATE OF DEATH

State No. .....

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): Johnnie L. Foster

2. SEX: Female

3a TIME OF DEATH: 8:03 A M

3b DATE OF DEATH (Month, Day, Yr): March 11, 1994

4. *SOCIAL SECURITY NUMBER: 408-42-1917

5a AGE—Last Birthday (Years): 74

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo, Day, Yr): Sept. 19, 1919

7 BIRTHPLACE (City and State or Foreign Country): Ripley, Tennessee

8a WAS DECEDENT A U.S. VETERAN? No

8b YEAR LAST SERVED IN U.S. ARMED FORCES? ----

9a PLACE OF DEATH (Check only one. See instructions): ☐ HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution, give street and number): 3801 Carey Street

9c CITY, TOWN OR LOCATION OF DEATH: East Chicago

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): William Foster

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker

12b KIND OF BUSINESS/INDUSTRY:

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: East Chicago

13d STREET AND NUMBER: 3801 Carey Street

13e ZIP CODE: 46312

13f INSIDE CITY LIMITS? ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12th Grade; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): John Wilson

19 MOTHER'S NAME (First, Middle, Maiden Surname): Louberta Taylor

INFORMANT

20a INFORMANT'S NAME (Type/Print): William Foster

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 Carey St. East Chicago, Indiana

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): March 16, 1994 Evergreen Memorial Park

21c LOCATION—City or Town, State: Hobart, Indiana

22a EMBALMER'S NAME: John V. Hower

22b EMBALMER'S LICENSE NO: FD08600440

23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: John R. Williams

24b LICENSE NUMBER (of Licensee): FD010[illegible]

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hixson-Williams Funeral Home FH8300152 48[illegible] Alexander Ave. East Chicago, In.

CAUSE OF DEATH

#30-392-1

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. metastatic cancer (Breast)

DUE TO (OR AS A CONSEQUENCE OF): b. ca of uterus

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

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)

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: [signature] MD

29c MEDICAL LICENSE NO: [illegible]29160

29d DATE SIGNED (Month, Day, Year): 3/11/94

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A.K. KAKODKAR 3700 Main ST E-Chicago In 46

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD.

32 DATE FILED (Month, Day, Year): 3-15-94

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): C[illegible]

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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