3CC

Local No. 88-0461

94020385

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ......

492 Monroe
Gary 46408
Frank Coleman

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

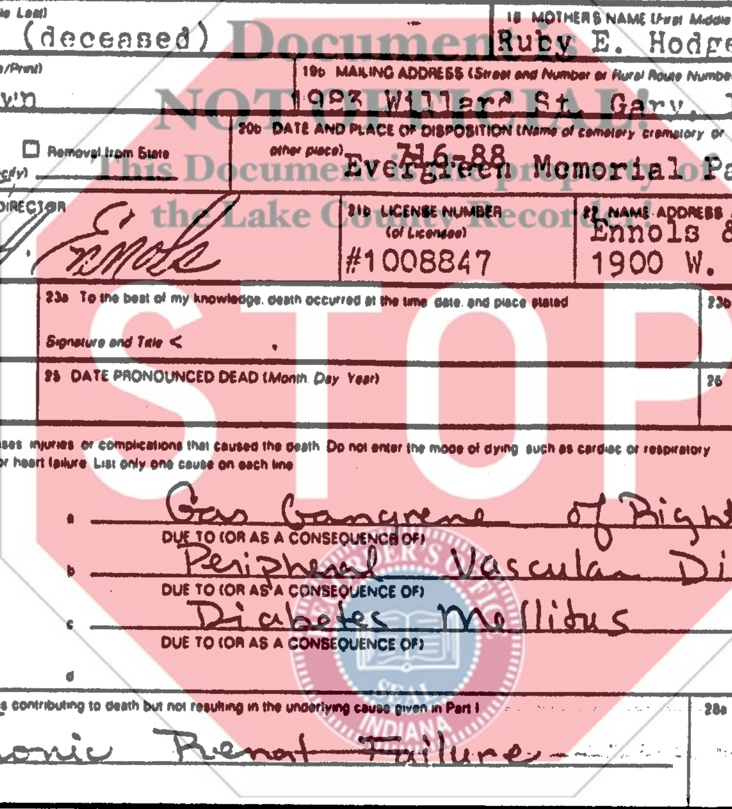
1 DECEASED—NAME (FIRST, MIDDLE, LAST): Alberta B. Coleman
2 SEX: F
3 DATE OF DEATH (Mo. Day Yr.): July 11, 1988
4 SOCIAL SECURITY NUMBER: 428-38-3065
5a AGE—Last Birthday (Years): 60
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Month, Day, Year): Sept 9-28
7 BIRTHPLACE (City and State or Foreign Country): Duncan, Mississippi
8 YEAR LAST SERVED IN US ARMED FORCES?
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): Methodist Northlake Hospital
9c CITY, TOWN OR LOCATION OF DEATH: Gary
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify):
11 SURVIVING SPOUSE (If wife give maiden name): Frank
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b KIND OF BUSINESS/INDUSTRY:
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 4192 Monroe Street
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: No
13g ZIP CODE: 46404
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify: XX
15 RACE—American Indian, Black, White, etc. (Specify): Black
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) 8; College (1-4 or 5+)

Key # 46-343-22
Patterson's Streets 1st Sub
L.20 Bl.2
S.15 FT. L.21 Bl.2

PARENTS
17 FATHER'S NAME (First, Middle, Last): Mose Brown (deceased)
18 MOTHER'S NAME (First, Middle, Maiden Surname): Ruby E. Hodges

INFORMANT
19a INFORMANT'S NAME (Type/Print): Ruby E. Brown
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1923 Willard St. Gary, Ind. 46404
Relationship: Mother

DISPOSITION
20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 7-16-88 Evergreen Memorial Park
20c LOCATION—City or Town, State: Hobart, Indiana
21a SIGNATURE OF FUNERAL DIRECTOR: Russel H. Ennols
21b LICENSE NUMBER (of Licensee): #1008847
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Ennols & Robinson Memorial Chap. 1900 W. 15th Ave. Gary, Indiana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PRONOUNCING PHYSICIAN ONLY
Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b LICENSE NUMBER
23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH
24 TIME OF DEATH: M
25 DATE PRONOUNCED DEAD (Month, Day, Year)
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

SEE INSTRUCTIONS
27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Gas Gangrene of Right Leg
DUE TO (OR AS A CONSEQUENCE OF)
b. Peripheral Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF)
c. Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF)
d.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

CAUSE OF DEATH
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Chronic Renal Failure
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
MAR 1 1994
Anna M. Anton
AUDITOR LAKE COUNTY

SEE INSTRUCTIONS
CERTIFIER
29a CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated
☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated
29b SIGNATURE AND TITLE OF CERTIFIER: Sandra L. Godson M.D.
29c LICENSE NUMBER: 01029625
29d DATE SIGNED (Month, Day, Year): July 14, 1988
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

HEALTH OFFICER
31 HEALTH OFFICER'S SIGNATURE: James T. Hedrick, Jr.
32 DATE FILED (Month, Day, Year): 7-15-1988

CORONER OR MEDICAL EXAMINER USE ONLY
33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month, Day, Year)
34b TIME OF INJURY
34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED
31089
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)

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