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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0257-94

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): Frizzell S. Gray
2 SEX: Male
3a TIME OF DEATH: 2:18 p.m.
3b DATE OF DEATH (Month Day Yr): January 19, 1994
4 SOCIAL SECURITY NUMBER: 435-12-1790
5a AGE—Last Birthday (Years): 73
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): January 19,1921
7 BIRTHPLACE (City and State or Foreign Country): Bosco, Louisiana
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
9a PLACE OF DEATH (Check only one See instructions): HOSPITAL [XX] Inpatient [ ] ER Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution give street and number): Methodist Hospital Southlake
9c CITY TOWN OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Veterine B. Baines
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Tool Repairman
12b KIND OF BUSINESS/INDUSTRY: USX Steel Corp.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1686 West 20th Place
13e ZIP CODE: 46404
13f INSIDE CITY LIMITS [XX] No [ ] 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+): 2 Years

PARENTS

18 FATHER'S NAME (First Middle Last): Sidmon Gray
19 MOTHER'S NAME (First Middle Maiden Surname): Bernice Harris

INFORMANT

20a INFORMANT'S NAME (Type/Print): Veterine B. Gray
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 1686 West 20th Place Gary, Indiana 46404
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): January 24, 1994 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 Sr.
24b LICENSE NUMBER (of Licensee): 01051701
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404 ~~83067704~~

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. Massive Cerebro Hemorrhage Accident
DUE TO (OR AS A CONSEQUENCE OF)
b. Hypertensive Heart Disease
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 MAR 18 1994

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

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

LAKE COUNTY

CERTIFIER

29a CERTIFIER (Check only one)
[X] 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: V Bruce
29c MEDICAL LICENSE NO: 01036051
29d DATE SIGNED (Month Day Year): 1/25/94

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): VIJAY DAVE, MD 3229 BROADWAY SUITE #104 GARY, IN 46409
31 HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D
32 DATE FILED (Month Day Year): January 26, 1994

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

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