

ATTENTION ESTATE: Disclosure of the fact we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

Mail Tax Bill To: 12554 S. Wallace Chgo, IL. 60628

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Cal No. 94-0204 94022101 State No. 1476

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

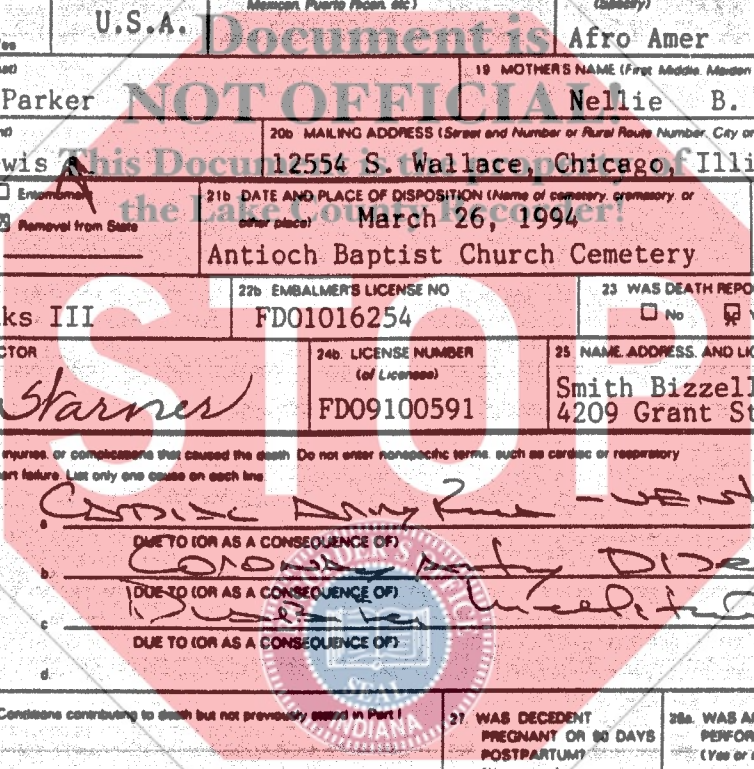
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Fred Lee Parker</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>05:11 P.M.</b>	3b DATE OF DEATH (Month, Day, Year) <b>March 21, 1994</b>	
4 SOCIAL SECURITY NUMBER <b>425-84-4678</b>	5a AGE—Last Birthday (Years) <b>51</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month, Day, Year) <b>Nov. 17, 1942</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Holly Springs, MS</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	8c PLACE OF DEATH (Check only one (See instructions)) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) <b>624 Virginia Street</b>	9b CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>	9c COUNTY OF DEATH <b>Lake</b>			
10 MARITAL STATUS (Specify) <b>Divorced</b>	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Steelworker</b>	12b KIND OF BUSINESS/INDUSTRY <b>Inland Steel Company</b>		
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN, OR LOCATION <b>Gary</b>	13d STREET AND NUMBER <b>624 Virginia Street</b>		
13e ZIP CODE <b>46402</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>Afro Amer</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) <b>Scott W. Parker</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Nellie B. Richmond</b>		20a INFORMANT'S NAME (Type/Print) <b>Carolyn Lewis</b>			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12554 S. Wallace, Chicago, Illinois 60628</b>		20c Relationship <b>Daughter</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Removal from State	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>March 26, 1994 Antioch Baptist Church Cemetery</b>		21c LOCATION—City or Town, State <b>Byhalia, Holly Springs, MS</b>		
22a EMBALMER'S NAME <b>Sherman G. Banks III</b>	22b EMBALMER'S LICENSE NO. <b>FDO1016254</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Paula L. Starnes</i>	24b LICENSE NUMBER (of Licensee) <b>FDO9100591</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Smith Bizzell Warner &amp; Son FH89900011 4209 Grant St., Gary, In. 46408</b>			
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. <b>Cardiac Arrhythmia - ventricular fibrillation</b> b. <b>Coronary Artery Disease</b> c. <b>Stroke by cerebral infarction</b> d. <b>Due to (or as a consequence of)</b>					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
27 WAS DECEDENT PREGNANT ON 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>			29c MEDICAL LICENSE NO. <b>27244</b>	29d DATE SIGNED (Month, Day, Year) <b>3/23/94</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 607 Type/Print) <b>Dr. Bryan H. Weiss, M.D. 202 E. 86th Place, Merrillville, Indiana 46410</b>					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month, Day, Year) <b>MAR 23 1994</b>		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year) <b>MAR 24 1994</b>	34b TIME OF INJURY	34c IN WHAT VEHICLE? (Yes or no)	
34a PLACE OF INJURY—At home farm street factory office building etc. (Specify)		34d LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>Anna N. Anton</i>			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) Yes Specify driver, passenger, pedestrian, etc.		1476	

Key # 44-65-34, Gary Land Co's 1st Sub R 34, Bl 65



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