

5cc 3c

91-0657

INDIANA STATE BOARD OF HEALTH

Jacqueline Riley  
3656 Delaware  
Gary 46409

Local No. 94023742

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

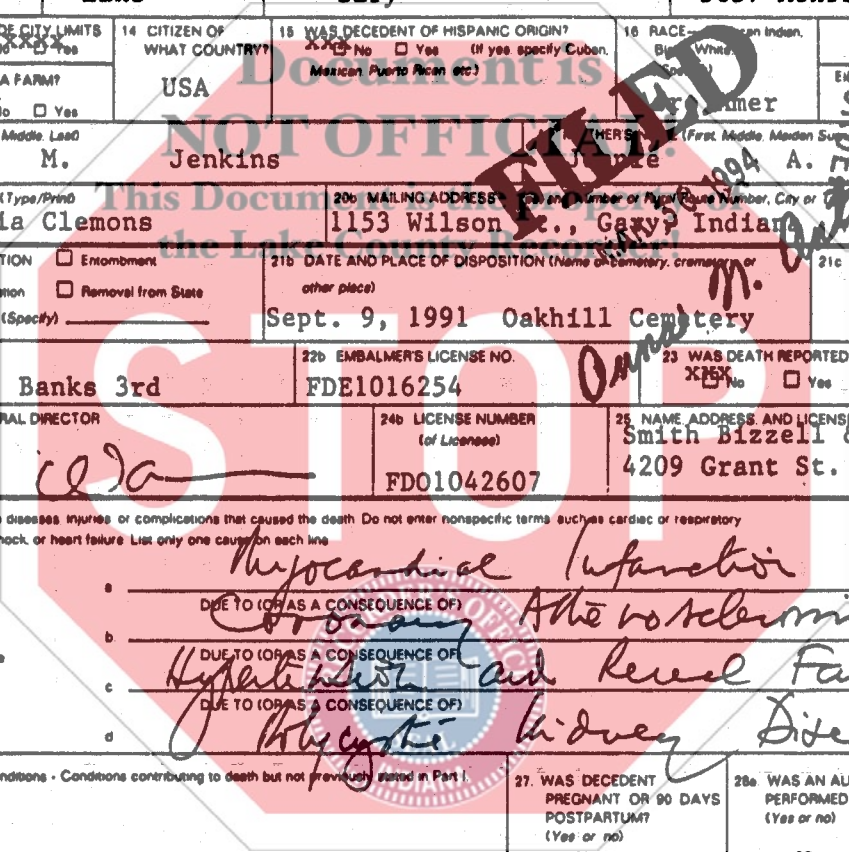
CERTIFIER

HEALTH OFFICER

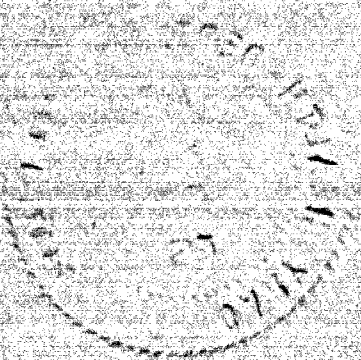
CORONER USE ONLY


1 DECEASED—NAME (First, Middle, Last) Virginia Smith		2 SEX female	3a TIME OF DEATH 1:48A	3b DATE OF DEATH (Month, Day, Year) September 4, 1991
4 SOCIAL SECURITY NUMBER 314-22-6484	5a AGE—Last Birthday (Years) 65	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) July 13, 1926
7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9a FACILITY NAME (If not institution, give street and number) Methodist Northlake		9b CITY, TOWN OR LOCATION OF DEATH Gary	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) James C. Smith	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Computer Programming		12b KIND OF BUSINESS/INDUSTRY Various Places
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 3637 Monroe Street	
13e ZIP CODE 46408	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE— Blk, White, Amer. Indian, etc.
17 DECEDENT'S EDUCATION (Specify highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) Herman M. Jenkins		
20a INFORMANT'S NAME (Type/Print) Odell Felicia Clemons		20b MAILING ADDRESS (City and State and Number of Rural Route Number, City or Town, State, Zip Code) 1153 Wilson St., Gary, Indiana 46404	20c Relationship Niece	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place) Sept. 9, 1991 Oakhill Cemetery		21c LOCATION (City or Town, State) Gary, Indiana
22a EMBALMER'S NAME Sherman G. Banks 3rd		22b EMBALMER'S LICENSE NO. FDE1016254	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR Edg [Signature]		24b LICENSE NUMBER (of Licensee) FDO1042607	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner FDH8300248 4209 Grant St. Gary, In. 46408	
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) Myocardial Infarction		DUE TO (OR AS A CONSEQUENCE OF) Coronary Atherosclerosis		1 hour
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last Hypertension and Renal Failure		DUE TO (OR AS A CONSEQUENCE OF) Hypertensive and Renal Failure		years
		DUE TO (OR AS A CONSEQUENCE OF) Hypertensive Kidney Disease		years
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
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 [Signature] Health Officer		29c. MEDICAL LICENSE NO. 30586	29d. DATE SIGNED (Month, Day, Year) September 4, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Michael Floyd, M.D. 600 Grant Street Gary, Indiana 46402				
31. HEALTH OFFICER'S SIGNATURE Bellevue E. Foster, mid med/2c				32. DATE FILED (Month, Day, Year) SEP. 5 1991
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)	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) 01855		
34g. DATE PROCLAIMED DSAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

# 46-528-7







CERTIFIED BY:  
  
HEALTH COMMISSIONER  
CITY OF GARY, IND.  
DATE MAR 30 1994