Jacqueline Riley
3656 Delaware
Gary 46409

91-0657

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 94023742

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	Virginia Smith
2. Sex	female
3a. Time of Death	1:48A M
3b. Date of Death (Month, Day, Yr)	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
9a. Place of Death (Check only one; see instructions)	HOSPITAL: XXX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	Methodist Northlake
9c. City, Town or Location of Death	Gary
9d. 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	XXXX ☐ No ☐ Yes
13g. On a Farm?	XXX No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XXX No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	Former
17. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)	1

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	Herman M. Jenkins
19. Mother's Name (First, Middle, Maiden Surname)	Jennie A. Allen

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	Odell Felicia Clemons
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1153 Wilson St., Gary, Indiana 46404
20c. Relationship	Niece

DISPOSITION

Field	Entry
21a. Method of Disposition	XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
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?	XXXX No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FD01042607
25. Name, Address, and License Number of Funeral Home	Smith Bizzell & Warner FDH8300248 4209 Grant St. Gary, In. 46408

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

	Cause	Approximate Interval Between Onset and Death
a	Myocardial Infarction	1 hour.
b	DUE TO (OR AS A CONSEQUENCE OF) Coronary Atherosclerosis	years
c	DUE TO (OR AS A CONSEQUENCE OF) Hypertension and Renal Failure	years
d	DUE TO (OR AS A CONSEQUENCE OF) Polycystic Kidney Disease.	years.

PART II. Other significant conditions - Conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Was Decedent Pregnant or 90 Days Postpartum? (Yes or no)	28a. Was an Autopsy Performed? (Yes or no)	28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)
No	No	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.

Field	Entry
29b. Signature and Title of Certifier	[signature]
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

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	Rebecca E. Foster, MD MPH/2c
32. Date Filed (Month, Day, Year)	SEP 5 1991

CORONER USE ONLY

Field	Entry
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	
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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#46-324-7

FILED MAY 5 1994

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE MAR 30 1994