12cc

9-026517

Local No. 443

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAY 25 1993 — Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	James W. Gaston
2 SEX	Male
3a TIME OF DEATH	8:35 P.M.
3b DATE OF DEATH (Month Day Yr)	May 20, 1993
4 SOCIAL SECURITY NUMBER	429-68-6435
5a AGE—Last Birthday (Years)	51
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	May 25, 1941
7 BIRTHPLACE (City and State or Foreign Country)	Winona, Mississippi
8a WAS DECEDENT A US VETERAN	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1968
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number)	St. Margaret Hospital
9c CITY, TOWN OR LOCATION OF DEATH	Hammond
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS	Married
11 SURVIVING SPOUSE (If wife give maiden name)	Shirley Dix
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Insulator
12b KIND OF BUSINESS/INDUSTRY	Local #17
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Gary
13d STREET AND NUMBER	1127 Morton Street
13e ZIP CODE	46404
13f INSIDE CITY LIMITS	☐ No [X] Yes
13g ON A FARM?	[X] No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U S A
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican etc.)	[X] No ☐ Yes
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+)	12th

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	William Gaston
19 MOTHER'S NAME (First Middle Maiden Surname)	Ethel Gary

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Shirley Gaston
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1127 Morton Street Gary, Indiana 46404
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	May 27, 1993 Fern Oak Cemetery
21c LOCATION—City or Town, State	Griffith, Indiana
22a EMBALMER'S NAME	Roosevelt Allen Sr.
22b EMBALMER'S LICENSE NO	#01051696
23 WAS DEATH REPORTED TO CORONER?	[X] No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	#08700646
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	#83007704 Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404

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. metastatic carcinoma of the pancreas — 6 mos.

DUE TO (OR AS A CONSEQUENCE OF)

b.

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

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I

Field	Entry
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)	

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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	36259
29d DATE SIGNED (Month Day Year)	May 22, 1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. J H Gleaton 7905 Calumet Munster, IN 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Franklin D. [signature]
32 DATE FILED (Month Day Year)	MAY 25, 1993

FILED

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	

APR 8 1994

Anna N. Anton

CL 445

Key # 43-167-36

Gary Heights L.34 BL.15 N.9FT L.35 BL.15 S.11FT L.37 BL.15

RECORDER

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