

CERTIFICATE OF DEATH

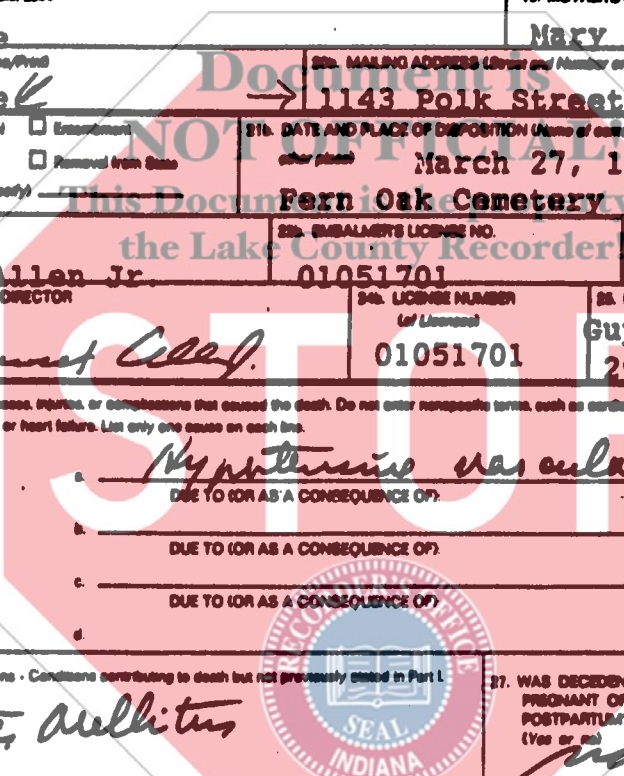
Local No. ...90.0216... 94026630

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) R. C. Core		2 SEX Male	3a TIME OF DEATH 3:27p	3b DATE OF DEATH (Month Day Yr) March 19, 1990
4 SOCIAL SECURITY NUMBER 381-16-9545	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days 0 0	5c UNDER 1 DAY Hours Minutes 0 0	6 DATE OF BIRTH (Mo. Day Yr) Aug. 27, 1921
7 BIRTHPLACE (City and State or Foreign Country) Opelika, Alabama	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 type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9a FACILITY NAME (If not institution, give street and number) 1143 Polk Street		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) Mary L. Guy	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Welder		12b KIND OF BUSINESS/INDUSTRY U S X Steel Corp.
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 1143 Polk Street	
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S A	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—American Indian, Black, White, etc. (Specify) Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 8th College (1-4 or 5+) None		18 FATHER'S NAME (First Middle Last) George Core		
19 MOTHER'S NAME (First Middle Maiden Surname) Mary Coleman		20 INFORMANT'S NAME (Type/Print) Mary L. Core		
21 MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1143 Polk Street Gary, IN 46407		22 RELATIONSHIP TO DECEASED Wife		
23a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removed from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		23b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 27, 1990 Fern Oak Cemetery		23c LOCATION (City or Town, State) Griffith, Indiana
24a EMBALMER'S NAME Roosevelt Allen Jr.		24b EMBALMER'S LICENSE NO. 01051701	25 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
26a SIGNATURE OF FUNERAL DIRECTOR <i>Roosevelt Allen Jr.</i>		26b LICENSE NUMBER (of Licensee) 01051701	26c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors Inc 8300770 2959 W. 11th Ave Gary, IN 4640	
28 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. Hypertensive vascular disease <i>indiv into</i>				
IMMEDIATE CAUSE (Final disease or condition resulting in death)				
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 Diabetes mellitus				
27a 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.		27b WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		27c WAS AN AUTOPSY PERFORMED? (Yes or no) No
27d WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		28a SIGNATURE AND TITLE OF CERTIFIER <i>Harold Bonstein MD</i>		
28b MEDICAL LICENSE NO. 01016449		28c DATE SIGNED (Month Day, Year) 3/29/90		
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (STEM 28) (Type/Print) Hershel Borastein MD 9200 Grant Gary, IN 46408				
30 HEALTH OFFICER'S SIGNATURE <i>Robert C. Fitch</i>		31 DATE FILED (Month Day, Year) APR 2 1990		
32 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		33a DATE OF INJURY (Month Day, Year) APR 8 1994	33b TIME OF INJURY AT WORK? (Yes or no)	33c HOW INJURY OCCURRED
34a PLACE OF INJURY (Street, factory, office, building, etc.)		34b LOCATION (Street and Number or Rural Route Number, City or Town, State) APR 8 1994		
34c DATE PRONOUNCED DEAD (Month Day, Year)		34d MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, etc. <i>Antonio M. Antonio</i>		

Key # 44-299-37, Guyland Co's 1143 Polk St. 39187



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