- 94026676 INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 90-0551 — State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. Deceased—Name (First, Middle, Last)	Arnold Kenneth Williams
2. Sex	Male
3a. Time of Death	2:25P.M.
3b. Date of Death (Month, Day, Yr.)	July 29,1990
4. Social Security Number	337 20 6712
5a. Age—Last Birthday (Years)	62
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo., Day, Yr.)	Feb.19,1928
7. Birthplace (City and State or Foreign Country)	Chicago, Illinois
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces?	1957
9a. Place of Death	Hospital: [X] Inpatient
9b. Facility Name	St Mary's Medical Center
9c. City, Town or Location of Death	Gary
9d. County of Death	Lake
10. Marital Status	Married
11. Surviving Spouse (If wife, give maiden name)	Amy Taylor
12a. Decedent's Usual Occupation	Supervisor Music & Art
12b. Kind of Business/Industry	Gary Community School Corporation
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town or Location	Gary
13d. Street and Number	1929 Tyler Court
13e. Zip Code	46407
13f. Inside City Limits	[X] Yes
13g. On a Farm?	[X] No
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin?	[X] No
16. Race	Black
17. Decedent's Education (College 1-4 or 5+)	6

PARENTS

18. Father's Name (First, Middle, Last)	George B. Williams
19. Mother's Name (First, Middle, Maiden Surname)	Leola A. Sunday

INFORMANT

20a. Informant's Name	Amy Williams
20b. Mailing Address	1929 Tyler Court Gary, In.
20c. Relationship	Wife

DISPOSITION

21a. Method of Disposition	[X] Burial
21b. Date and Place of Disposition	August 1,1990 Ridgelawn Cemetery
21c. Location—City or Town, State	Gary, Indiana
22a. Embalmer's Name	Roosevelt Allen Sr.
22b. Embalmer's License No.	01051696
23. Was Death Reported to Coroner?	[X] No
24a. Signature of Funeral Director	Roosevelt Allen Sr. (signature)
24b. License Number (of Licensee)	01051701
25. Name, Address, and License Number of Funeral Home	83007704 Guy & Allen funeral Directors,Inc. 2959 W.11th Ave. Gary, In.46404

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Metastatic Squamous Cell Lung Cancer 7 mos — Approximate Interval Between Onset and Death

DUE TO (OR AS A CONSEQUENCE OF):
b.

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

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): 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

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.

29b. Signature and Title of Certifier: Barbara L Fuller, MD.

29c. Medical License No.: 01034701

29d. Date Signed (Month, Day, Year): 8/6/90

30. Name and Address of Person Who Completed Cause of Death (Item 26): Barbara L. Fuller, M.D. 3229 Broadway Gary, IN 46409

HEALTH OFFICER

31. Health Officer's Signature: (signature)

32. Date Filed (Month, Day, Year): AUG 8 1990

FILED

CORONER USE ONLY

33. Manner of Death: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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)
34g. Date Pronounced Dead (Month, Day, Year)
34h. Motor Vehicle Accident? (Yes or no)

APR 8 1994

Oscar N. Anton (signature)

00501

State Form 10110 (R2/3-88)

Handwritten in left margin: TKS 1929 Tyler Ct 46407 ... Indiana Third Book ... 46-585-7

Stamped: SEP 18 1994 — RECORDER — STATE OF INDIANA

HEALTH COMMISSIONER
CITY OF GARY, IND.
APR 08 19[illegible]