INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 93-0075

94027020

State No. Key #4.7-30-142 Unit #25

Security Realty Co's 1st Add Lots 142, Block 2

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ODESTER SIMON PARKER
2. SEX: MALE
3a. TYPE OF DEATH: P
3b. DATE OF DEATH (Month, Day, Yr.): JANUARY 29,1993
4. SOCIAL SECURITY NUMBER: 432-26-3802
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo., Day, Yr.): JUNE 18,1914
7. BIRTHPLACE (City and State or Foreign Country): FOREST CITY, ARKANSAS
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9. PLACE OF DEATH (Check only one): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9a. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL NORTHLAKE
9c. CITY, TOWN OR LOCATION OF DEATH: GARY
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Legally): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): LEONA BOLES
12a. DECEDENT'S USUAL OCCUPATION (Kind of work done during most of working life. Do not use retired): FURNACE MAN
12b. KIND OF BUSINESS/INDUSTRY: STEEL MILL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 2415 W. 21st. AVE.
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?: [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): BLK.
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th.; College (1-4 or 5+): [illegible]

PARENTS

18. FATHER'S NAME (First, Middle, Last): GARFIELD PARKER SR.
19. MOTHER'S NAME (First, Middle, Maiden Surname): PEARLIE NEWELL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LEONA PARKER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2415 W. 21st. AVE. GARY, IND. 46404
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): OAK HILL CEMETERY FEBRUARY 4,1993
21c. LOCATION—City or Town, State: GARY
22a. EMBALMER'S NAME: JOHN V. HOWER
22b. EMBALMER'S LICENSE NO: 8600440
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Wilbert E. Hower
24b. LICENSE NUMBER (of Licensee): 014618
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: HOWER FUNERAL HOME 3002518, 1628 WASHINGTON ST. GARY. IND.

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter terminal events 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. Pneumonia

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. DUE TO (OR AS A CONSEQUENCE OF): X; c. DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: X Spinal Stenosis Paraplegia

27. WAS DECEDENT PREGNANT OR 60 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: X [illegible] MD
29c. MEDICAL LICENSE NO: 0103675A
29d. DATE SIGNED (Month, Day, Year): X 2/2/93
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (Type/Print): X [illegible] 706 Gary IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): FEB 8 1993

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. [illegible] INJURY OCCURRED
34d. 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)

FILED

APR 11 1994

34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: Anna M. Anton

0059

Fairmount Park Add Lot 5+6, Block 1 Key #43-1-546 Unit #25

SDH 66-804 State Form 10110 (R2/3-89) DEA CERT/PD 1