94028696

Local No. 93-0781

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	James Rodgers
2 SEX	Male
3a TIME OF DEATH	4:32 A.M.
3c DATE OF DEATH (Month Day Year)	October 8, 1993
4 SOCIAL SECURITY NUMBER	430-03-6612
5a AGE—Last Birthday (Years)	73
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	Oct. 22, 1919
7 BIRTHPLACE (City and State or Foreign Country)	Little Rock, Arkansas
8a WAS DECEDENT A US VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	1944
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. Mary Medical Center
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)	Augustine Moore
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Luderman
12b KIND OF BUSINESS/INDUSTRY	USX Steel Coke Plant
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Gary
13d STREET AND NUMBER	1215 Garfield 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?	[X] No [ ] Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc. (Specify)	Afro Amer
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	10

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Clarence Rodgers Sr.
19 MOTHER'S NAME (First Middle Maiden Surname)	Fannie Unavailable

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Augustine Rodgers
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1215 Garfield St., Gary, IN 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)	October 12, 1993 Evergreen Memorial Park
21c LOCATION (City or Town, State)	Hobart, Indiana
22a EMBALMER'S NAME	Sherman G. Banks III
22b EMBALMER'S LICENSE NO	FD01016254
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Paula L. Warner
24b LICENSE NUMBER (of Licensee)	FD09100591
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Smith Bizzell Warner & Son, 4209 Grant St., Gary, IN 46408 — FH89900011

#43-20-4

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. acute cardiorespiratory arrest

DUE TO (OR AS A CONSEQUENCE OF)

b. acute cerebro vascular accident

DUE TO (OR AS A CONSEQUENCE OF)

c. Hypertension

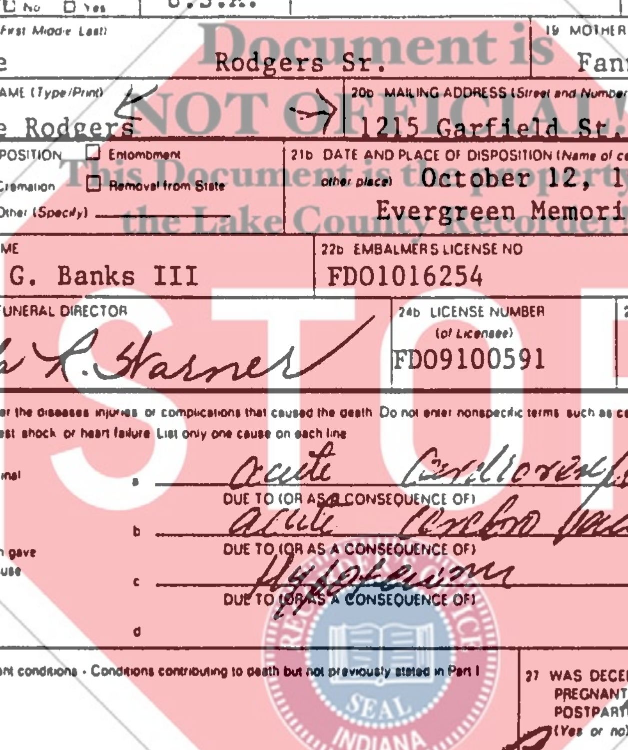
DUE TO (OR AS A CONSEQUENCE OF)

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)	No



FILED APR 15 1994

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	01026051
29d DATE SIGNED (Month Day Year)	10/18/93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Vijay Dave, M.D. 3229 Broadway Gary, Indiana 46408

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature]
32 DATE FILED (Month Day Year)	OCT 20 1993

CORONER USE ONLY

Field	Entry
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) If yes specify driver, passenger, pedestrian, etc.	

SDH06-004 State Form 10110 (R/1-92) DEATHCER/PD 1

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