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Local No. 90_0250

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. 94028822

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Ozie B. Koger	Male	6:45 p.m.	March 23, 1990

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
428-44-2918	61			November 26, 1928	Itta Bena, Mississip

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR(S) SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1953	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Methodist Hospital Northlake Campus	Gary	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Mildred L. Wallace	Steelworker	USX Big Mill

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Gary	4338 Kentucky Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)
46409	[X] No [ ] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes (If yes, specify Cuban,	Afro Amer.	Elementary/Secondary (0-12): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Denson	Emma Lampkin

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Mildred L. Koger	4338 Kentucky St., Gary, Indiana 46409	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)	APR 15 1994 March 28, 1990 Evergreen Cemetery	Hobart, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Sherman G. Banks III	FDO 10162	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
	FDO 1042607	Smith Bizzell & Warner, Inc. FDH30024 2295 Washington St., Gary, Ind. 46407

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter non-specific 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. massive intracerebral hemorrhage	2 hrs
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. hypertension DUE TO (OR AS A CONSEQUENCE OF)	many yrs
	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

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Charles Chuman	IN 1035829	3/29/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Charles Chuman, M.D. 8701 Broadway Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Rebecca E. Easton MD MPH/SC	MAR. 30 1990

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)
	06383

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

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