INDIANA STATE BOARD OF HEALTH

Local No 89-0575 94029173 — CERTIFICATE OF DEATH — State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Velar Ann Pruitt
2. SEX: Female
3a. TIME OF DEATH: 2:40 A.M.
3b. DATE OF DEATH (Month, Day, Yr.): September 2-1989
4. SOCIAL SECURITY NUMBER: 312-38-3527
5a. AGE—Last Birthday (Years): 54
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): 03-27-
7. BIRTHPLACE (City and State or Foreign Country): Smithville, Mississippi
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NO
8e. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☑ 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): Robert Pruitt
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): TEACHER
12b. KIND OF BUSINESS/INDUSTRY: SCHOOL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 2581 MONROE ST.
13e. ZIP CODE: 4647
13f. INSIDE CITY LIMITS: ☐ No ☑ Yes
13g. ON A FARM? ☑ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☑ No ☐ 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 (0-12): 12; College (1-4 or 5+): 4 YEARS

PARENTS

18. FATHER'S NAME (First, Middle, Last): LESTER LOGAN
19. MOTHER'S NAME (First, Middle, Maiden Surname): Leona Poole

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Robert Pruitt
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2581 MONROE Gary, IND 46407
20c. Relationship: SPOUSE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☐ Cremation ☑ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEPTEMBER 9, 1989 MOSANIC Cemetery
21c. LOCATION—City or Town, State: Amory, Mississippi
22a. EMBALMER'S NAME: LEON COLEMAN JR
22b. EMBALMER'S LICENSE NO: 243
23. WAS DEATH REPORTED TO CORONER? ☑ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Leon Coleman Jr
24b. LICENSE NUMBER (of Licensee): 104-5230
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Powell-Coleman Funeral Home P.O.B. 1534 Gary, Ind 46402-1534

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. Metastatic Breast Cancer

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: - Diabetes mellitus - Hypertension

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):
☑ 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: Claudia Nicholson
29c. MEDICAL LICENSE NO: 31281
29d. DATE SIGNED (Month, Day, Year): 9/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 3535 Broadway - Gary, IN.
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): 9-5-89

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) (If yes, specify driver, passenger, pedestrian, etc.):

APR 18 1994
AUDITOR LAKE COUNTY
31080

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1