94029612
92-0917

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. .... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Callie D. Mabone
2 SEX: Female
3a TIME OF DEATH: 6:00 p.m
3b DATE OF DEATH (Month Day Yr): December 27, 1992
4 SOCIAL SECURITY NUMBER: 305-32-5303
5a AGE—Last Birthday (Years): 68
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo Day Yr): March 12, 1924
7 BIRTHPLACE (City and State or Foreign Country): Eads, TN
8a WAS DECEDENT A U.S. VETERAN? No
8b YEAR LAST SERVED IN US ARMED FORCES? N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b 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 (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Joe L. Mabone
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2323 Johnson St
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
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): 8th; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Edgar Jones
19 MOTHER'S NAME (First Middle Maiden Surname): Emma Eddeton

INFORMANT

20a INFORMANT'S NAME (Type/Print): Joe L. Mabone
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2323 Johnson St Gary, IN 46407
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): January 2, 1993 Evergreen Cemetery
21c LOCATION—City or Town, State: Hobart, Indiana
22a EMBALMER'S NAME: Patsy Allen
22b EMBALMER'S LICENSE NO: 01045736
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature] Allen Sr.
24b LICENSE NUMBER (of Licensee): 01051696
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. Gary, IN 46404

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	GLIOBLASTOMA MULTIFORME- BRAIN	1 YR
DUE TO (OR AS A CONSEQUENCE OF) b.		
DUE TO (OR AS A CONSEQUENCE OF) c.		
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.
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): ---

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: [signature]
29c MEDICAL LICENSE NO: 01030107
29d DATE SIGNED (Month Day Year): 12-30-92
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Barai 125 East 89 th Ave. Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): JAN. 1 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 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.

FILED
APR 19 1994
Anna N. Antonas
AUDITOR LAKE COUNTY
31146
8.00

Washington Park Sub L.43 BL.1 Key #47-202-43

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