STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

94031697

94 APR 27 AM 11:27

SAMUEL ORLICH
RECORDER

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 94-0153 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First Middle Last)	Ethel Rose Jones
2. SEX	Female
3a. TIME OF DEATH	1:31A
3b. DATE OF DEATH (Month Day Yr)	March 1, 1994
4. SOCIAL SECURITY NUMBER	343-26-2278
5a. AGE—Last Birthday (Years)	62
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	MAR 3, 1931
7. BIRTHPLACE (City and State or Foreign Country)	Atlanta, Georgia
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a. PLACE OF DEATH (Check only one)	HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	Methodist Northlake
9c. CITY, TOWN, OR LOCATION OF DEATH	Gary
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS	Widowed
11. SURVIVING SPOUSE (If wife, give maiden name)	NONE
12a. DECEDENT'S USUAL OCCUPATION	Secretary
12b. KIND OF BUSINESS/INDUSTRY	Social Security Adm.
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary
13d. STREET AND NUMBER	2658 Buchanan Street
13e. ZIP CODE	46407
13f. INSIDE CITY LIMITS	☐ No [X] Yes
13g. ON A FARM?	[X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN?	[X] No ☐ Yes
16. RACE	Afro Am
17. DECEDENT'S EDUCATION (Elementary/Secondary (0-12); College (1-4 or 5+))	2

PARENTS

Field	Entry
18. FATHER'S NAME (First Middle Last)	Leroy Aycox Sr.
19. MOTHER'S NAME (First Middle Maiden Surname)	Sara Mae Fulton

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Cheryl Anne Jones
20b. MAILING ADDRESS	2658 Buchanan St., Gary, Indiana 46407
20c. Relationship	Daughter

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☐ Burial ☐ Cremation ☐ Donation ☐ Entombment [X] Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION	MAR 5, 1994 Burr Oak Cemetery
21c. LOCATION—City or Town, State	Alsip, Illinois
22a. EMBALMER'S NAME	Sherman G. Banks
22b. EMBALMER'S LICENSE NO.	FDE1016254
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	FH88900011 Smith Bizzell Warner & Son 4209 Grant St., Gary, In. 46408

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. COMA
DUE TO (OR AS A CONSEQUENCE OF):
b. HEPATIC FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. CIRRHOSIS LIVER
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Approximate Interval Between Onset and Death

PART II. Other significant conditions—Conditions contributing to death but not resulting in the underlying cause in Part I: Renal Failure, Sepsis, Diabetes

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 27 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. MEDICAL LICENSE NO.: 01027943
29d. DATE SIGNED (Month Day Year): 3/2/94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. A. M. Khokhar, 7899 Taft Street, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month Day Year): MAR 03 1994

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.

Handwritten in left margin: Key # 45-320-17 Lincoln Park add L 69 + D 10 blk 3 B1. 3 P70

SDH05-004 State Form 10110 (R/1-92) DEATHCERT.PD

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