Local No. 133

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. HOLD FOR: THE TITLE SEARCH CO

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 Deceased—Name (First Middle Last)	Willie C. Henderson, Sr
2 Sex	Male
3a Time of Death	1:12 A M
3b Date of Death (Month Day Yr)	May 2, 1991
4 Social Security Number	349-32-8441
5a Age—Last Birthday (Years)	49
5b Under 1 Year (Months / Days)	
5c Under 1 Day (Hours / Minutes)	
6 Date of Birth (Mo Day Yr)	July 23, 1941
7 Birthplace (City and State or Foreign Country)	Canton, Mississippi
8a Was Decedent a US Veteran?	No
8b Year Last Served in US Armed Forces?	------
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)	St. Catherine Hospital
9c City, Town or Location of Death	East Chicago
9d County of Death	Lake
10 Marital Status (Specify)	Married
11 Surviving Spouse (If wife give maiden name)	Dallis D. Addison
12a Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Steelworker (retired)
12b Kind of Business/Industry	Blaw Knox
13a Residence—State	Indiana
13b County	Lake
13c City, Town or Location	East Chicago
13d Street and Number	3718 Catalpa Street
13e Zip Code	46312
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16 Race—American Indian, Black, White, etc (Specify)	Black
17 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	12th Grade
College (1-4 or 5+)	

PARENTS

Field	Entry
18 Father's Name (First Middle Last)	Lee Henderson
19 Mother's Name (First Middle Maiden Surname)	Lucille Jackson

INFORMANT

Field	Entry
20a Informant's Name (Type/Print)	Dallis D. Henderson
20b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3718 Catalpa St. East Chicago, In 46312
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)	May 14, 1991 Evergreen Memorial Park
21c Location—City or Town, State	Hobart, Indiana
22a Embalmer's Name	Tracy Cheri Williams
22b Embalmer's License No	FD08600238
23 Was Death Reported to Coroner?	[X] No [ ] Yes
24a Signature of Funeral Director	Tracy Cheri Williams
24b License Number (of Licensee)	FD08600238
25 Name, Address, and License Number of Funeral Home	Hinton & Williams Funeral Home, 4859 Alexander Avenue CFH83001520, East Chicago, In 46312

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. hypoxic encephalopathy

DUE TO (OR AS A CONSEQUENCE OF)

b. Ventricular fibrillation

DUE TO (OR AS A CONSEQUENCE OF)

c. Cardiomyopathy

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)	------

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	5000 2119
29d Date Signed (Month Day Year)	5-10-91
30 Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	M.A. Rhamany, M.D. 3801 Ridge Rd. Highland, Indiana

HEALTH OFFICER

Field	Entry
31 Health Officer's Signature	Dr. Jim Razkovich
32 Date Filed (Month Day Year)	5-13-91

CORONER USE ONLY

Field	Entry
33 Manner of Death	[ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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	

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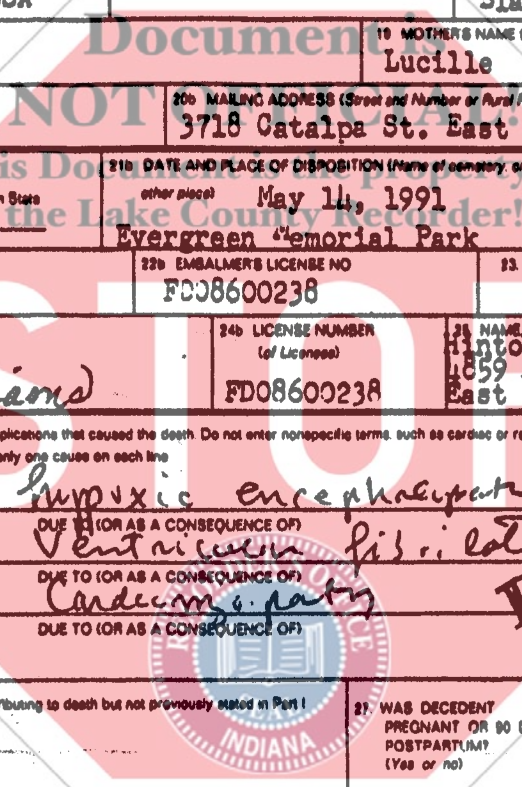
SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1



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