INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1 ..... CERTIFICATE OF DEATH ..... State No. 95000172

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-16-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Willie Foster
2. SEX: Male
3a. TIME OF DEATH: 6:17 P M
3b. DATE OF DEATH (Month, Day, Year): December 30, 1993
4. SOCIAL SECURITY NUMBER: 420-16-3041
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1919
7. BIRTHPLACE (City and State or Foreign Country): Macon County, Alabama
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ----
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): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Divorced
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): Operator (Retired)
12b. KIND OF BUSINESS/INDUSTRY: Inland Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 3938 Drummond St.
13e. ZIP CODE: 46312
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): 4th Grade; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Ruben Foster
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Brown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Christine Hunter
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3938 Drummond St. East Chicago, Indiana
20c. Relationship: Friend

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 4, 1994 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Ind.
22a. EMBALMER'S NAME: Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO: FD08600238
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL SERVICE FACILITY: Hinton-Williams Funeral Home 3008 4859 Alexander Ave. East Chicago, In.

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. Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Congestive Heart Failure
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: b. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiomyopathy
c. DUE TO (OR AS A CONSEQUENCE OF): Pneumonia
d. DUE TO (OR AS A CONSEQUENCE OF):

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: Napoleon L. Santos M.D.
29c. MEDICAL LICENSE NO: 30678
29d. DATE SIGNED (Month, Day, Year): 1-03-94

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): NAPOLEON L SANTOS M.D. 8129 Kennedy AVE. Highland 46322
31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): 1-3-94

CORONER USE ONLY

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.

FILE

FILED JAN 04 1995

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1

Johnnie Wright) 3571 Black Ave. E.C. 46312