Local No. 94-0071

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Dorothy Johnson
2. SEX: Female
3a. TIME OF DEATH: 12:05P
3b. DATE OF DEATH (Month, Day, Yr.): January 31, 1994
4. SOCIAL SECURITY NUMBER: 353-22-5436
5a. AGE—Last Birthday (Years): 71
6c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): FEB 26, 1922
7. BIRTHPLACE (City and State or Foreign Country): Snow Hill, Maryland
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. See instructions.): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
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 (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John A. Johnson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Homemaker
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13e. STREET AND NUMBER: 2050 Roosevelt St.
13d. ZIP CODE: 46404
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): Afro Am
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Herman Martin
19. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Collick

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John A. Johnson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2050 Roosevelt St., Gary, Indiana 46404
20c. RELATIONSHIP: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 4, 1994 Fern Oak Cemetery
21c. LOCATION—City or Town, State: Griffith, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254 X
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Paula R. Starner
24b. LICENSE NUMBER (of Licensee): FD0100591
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 nonmedical 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. Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.
Time interval between onset and death: FEB 07 1995
PART II. Other significant conditions. Conditions contributing to death but not related to cause given 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): 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) and manner 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) and manner 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.: 01033117
29d. DATE SIGNED (Month, Day, Year): 2/1/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Bayne W. Spotwood, 636 East 21st Avenue, Gary, Indiana 46407

HEALTH OFFICER

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

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.)

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

001239

FILED
SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 FEB 27 AM 10:36
RECORDER