ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 94-0571

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): EMMETT FIFE
2 SEX: MALE
3a TIME OF DEATH: 4:30p.m.
3b DATE OF DEATH (Month Day Yr): Aug.4,1994
4 SOCIAL SECURITY NUMBER: 420-34-4666
5a AGE—Last Birthday (Years): 64
5b UNDER 1 YEAR (Months Days):
5c UNDER 1 DAY (Hours Minutes):
6 DATE OF BIRTH (Mo Day Yr): July 6,1930
7 BIRTHPLACE (City and State or Foreign Country): Centre, Alabama
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 Hospital Northlake Campus
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): Helen Allen
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer
12b KIND OF BUSINESS/INDUSTRY: Inland Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1508 E. 36th. Avenue
13e ZIP CODE: 46408
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 Amer.
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th. Grade; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Leonard Fife
19 MOTHER'S NAME (First Middle Maiden Surname): UNKNOWN

INFORMANT

20a INFORMANT'S NAME (Type/Print): Helen Fife
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town State Zip Code): 1508 E. 36th. Ave., Gary, Indiana
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): Aug. 12,1994 Evergreen Mem. Park Cemetery
21c LOCATION—City or Town State: Hobart, Indiana
22a EMBALMER'S NAME: Celeste P. Kaufman
22b EMBALMER'S LICENSE NO: FDE:1033626
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Celeste P. Kaufman
24b LICENSE NUMBER (of Licensee): FDH:302411
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kaufman Funeral Home/302411 421 W. 5th. Ave., Gary, Indiana

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. Pendarmen Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II Other significant conditions Conditions contributing to death but not directly related in Part I: Cerebral infarction due to Hypertensive vascular disease

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): N/A

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: Jerachel Bornstein MD
29c MEDICAL LICENSE NO: 010164A9
29d DATE SIGNED (Month Day Year): 8/8/94

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE
32 DATE FILED (Month Day Year): AUG 09 199

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

04-86-174 #

STATE OF INDIANA LAKE COUNTY FILED 85 FEB 22 AM 10:48 RECORDER

FILED FEB 28 1995 SAM ORLICH AUDITOR LAKE COUNTY INDIANA

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1