

\*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

CERTIFICATE OF DEATH

Local No. 3213-94

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Willie Roosevelt Patton		2 SEX Male	3a TIME OF DEATH 9:00A	3b DATE OF DEATH (Month Day Year) December 14, 1994	
4 SOCIAL SECURITY NUMBER 420-22-3211	5a Age at Birth (Year) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) October 12, 1926	
7 BIRTHPLACE (City and State or Foreign Country) Bessemer, Alabama	8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES N/A	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution give street and number) South Lake Methodist Hospital		9b CITY, TOWN OR LOCATION OF DEATH Merrillville	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS married	11 SURVIVING SPOUSE (If wife, give maiden name) Adriana U. Rhodes	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Mail Carrier	12b KIND OF BUSINESS/INDUSTRY U.S. P.O.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 2925 West 19th Avenue		
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) Black	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) College (1-4 or 5+) 12 <input checked="" type="checkbox"/> ---		18 FATHER'S NAME (First Middle Last) Willie Macon Patton			
19 MOTHER'S NAME (First Middle Maiden Surname) Marcie Ree Spencer		20a INFORMANT'S NAME (Type/Print) Adriana U. Patton			
20b MAILING ADDRESS (Street, Box Number or Rural Route Number, City or Town, State, Zip Code) 2925 West 19th Avenue, Gary, IN		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal for Burial <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other) December 20, 1994 Lincoln Cemetery		21c LOCATION—City or Town, State Chicago, IL	
22a EMBALMER'S NAME Abe Saunders		22b EMBALMER'S LICENSE NO. Chicago 011021	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of Licensee) 1045184	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Homes #00028 5840 Hohman Ave, Hammond, IN / Gat. 19 10133 S. Halsted, Chicago, IL		
26 PART I: Enter the diseases, injuries, or conditions 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. <i>Hepatic Coma</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Liver metastasis</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Cancer of Cecum</i> DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS if any, which gave rise to the immediate cause stating the underlying cause last <i>Diabetes mellitus</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	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>[Signature]</i>			
29c. MEDICAL LICENSE NO. 01033371		29d. DATE SIGNED (Month Day Year) December 15, 1994			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Michael Kovacich M.D., 111 East 89th Avenue, Merrillville, Indiana					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander T. Williams MD</i>		32. DATE FILED (Month Day Year) December 20, 1994			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE 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) JUN 2 1995 SAM ORLICH AUDITOR LAKE COUNTY			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, or pedestrian.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



STATE OF INDIANA  
LAKE COUNTY  
FILED  
JUN 15 1995

Key # 43-261-7

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