

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. HEALTH DEPT

No. 90-210

PRINT
N
ANENT
K INK

NT

S
IANT

ITION

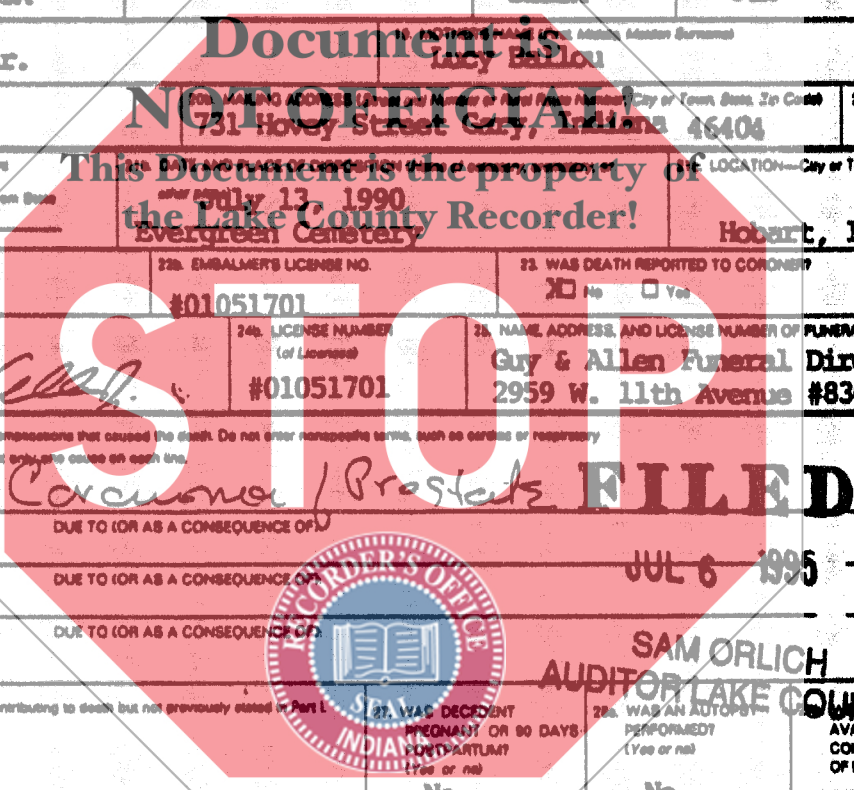
OF

ER

R

ER
LY

1. DECEASED—NAME (Print, Middle, Last) Curtis Williamson		2. SEX Male	3a. TIME OF DEATH 4:05 p.m.	3b. DATE OF DEATH (Month, Day, Year) July 9, 1990	
4. SOCIAL SECURITY NUMBER 410-26-7710	5a. AGE—Last Birthday (Years) 79	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) June 9, 1911	
7. BIRTHPLACE (City, State or Foreign Country) Tennessee	8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None		
9. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Institution <input type="checkbox"/> Other (Specify) <input type="checkbox"/> EYE/ENT/POA <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Residence					
9a. FACILITY NAME (If not institution, give street and number) 731 Hovey Street		9b. CITY, TOWN OR LOCATION OF DEATH Gary		9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Gracie Strayhorn	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)		12b. KIND OF BUSINESS/INDUSTRY USX	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Gary	13d. STREET AND NUMBER 731 Hovey Street		
14a. ZIP CODE 46404	14b. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14c. CITIZEN OF WHAT COUNTRY? USA	14d. WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14e. RACE—American Indian, Black, White, etc. (Specify) Black	
15. FATHER'S NAME (Print, Middle, Last) Leroy Williamson Sr.		16. MOTHER'S NAME (Print, Middle, Maiden Surname) Lacy Ballou			
20a. INFORMANT'S NAME (Type/Print) Gracie Williamson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 Hovey Street, Gary, Indiana 46404	20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (City or Town, State) July 13, 1990 Evergreen Cemetery		21c. LOCATION—City or Town, State Hobart, Indiana	
22a. EMBALMER'S NAME Roosevelt Allen Jr.		22b. EMBALMER'S LICENSE NO. #01051701	22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Roosevelt Allen Jr.</i>		24b. LICENSE NUMBER (of Licensee) #01051701	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue #83007704		
25. PART I. Enter the process, injury, or combination 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.					
<p>a. IMMEDIATE CAUSE (Final disease or condition resulting in death) Cocaine / Prostate DUE TO (OR AS A CONSEQUENCE OF)</p> <p>b. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF)</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF)</p>					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.					
27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28. WAS AN AUTOPSY PERFORMED? (Yes or no) No		29. COPY EVIDENCE AVAILABLE PROPER COMPLETION OF CAUSE OF DEATH? (Yes or 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>Charles D. Williams</i>		29c. MEDICAL LICENSE NO. 27353	29d. DATE SIGNED (Month, Day, Year) 7/17/90		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (LIST IN 26) (Type/Print) CHARLES D. WILLIAMS, 8585 Broadway Suite 705 Merrillville IN					
31. HEALTH OFFICER'S SIGNATURE <i>Charles D. Williams</i>			32. DATE FILED (Month, Day, Year) JUL 12 1990		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> 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.			

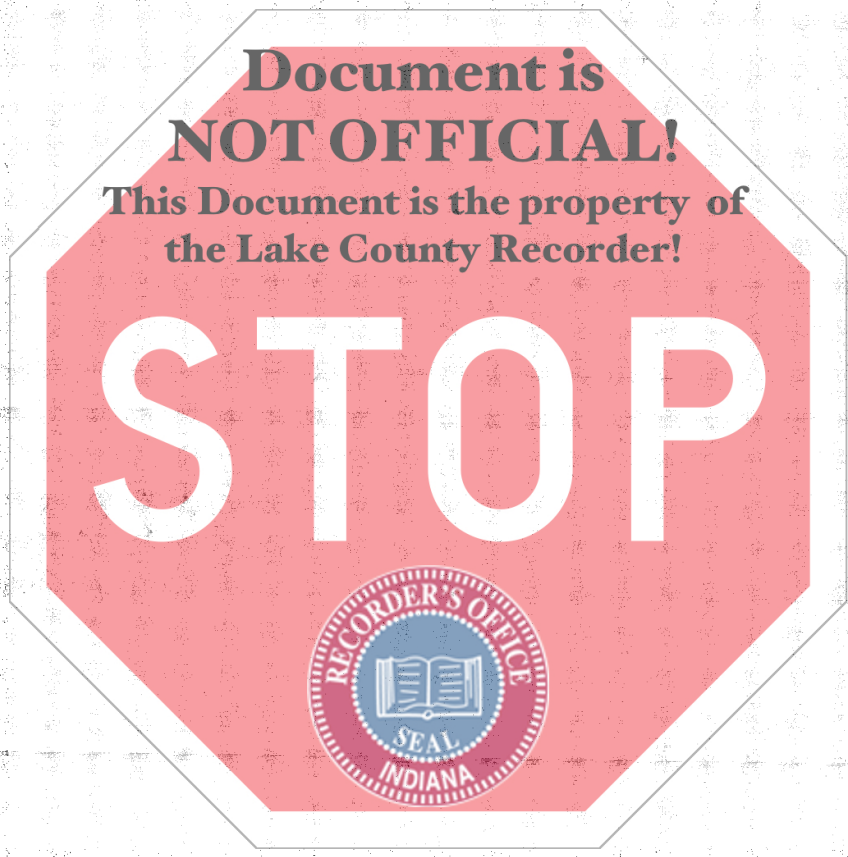



95097802
 STATE OF INDIANA
 LAKE COUNTY
 FILED FOR RECORD
 JUL 6 AM 11:10
 MARGARET L. JENSEN
 RECORDER

000292
900



4401006



CERTIFIED BY

 HEALTH COMMISSIONER
 CITY OF GARY, IND.
 DATE Jul 06 1995