No. 90-210

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

HEALTH DEPT

PRINT IN PERMANENT INK

1. DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Year)
Curtis Williamson		Male	4:05 p.m.	July 9, 1990

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR (Months, Days)	5c. UNDER 1 DAY (Hours, Minutes)	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
410-26-7710	79			June 9, 1911	Tampico

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
No	None	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
731 Hovey Street	Gary	Lake

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
Married	Gracie Strayhorn	Burner	USX

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Gary	731 Hovey Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46404	☐ No ☒ Yes	☒ No ☐ Yes	USA		Black	6th	9

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Leroy Williamson Sr.	Lucy Ballou

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Gracie Williamson	731 Hovey Street Gary, Indiana 46404	Wife

21a. METHOD OF DISPOSITION	21b. PLACE AND LOCATION OF DISPOSITION (Cemetery, Crematory, Other Place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	July 13, 1990 Evergreen Cemetery	Hobart, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Roosevelt Allen Jr.	#01051701	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Roosevelt Allen	#01051701	Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue #83007704

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. Coronary / Prostate Cancer

DUE TO (OR AS A CONSEQUENCE OF): b.

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POST-PARTUM? (Yes or no)	28. WAS AN AUTOPSY PERFORMED? (Yes or no)	29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	

FILED
JUL 6 1990
SAM ORLICH
AUDITOR LAKE COUNTY

RECORDER'S OFFICE LAKE COUNTY INDIANA

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
JUL 16 AM 11 10
MARGARET E. BELL
RECORDER

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Charles D. Williams	27353	7/17/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Charles D. Williams 8585 Broadway Suite 765 Merrillville IND

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) JUL 12 1990

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)

000292

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, etc.

SBH08-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

Macarthur Drake 504 Bl

CERTIFIED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE JUL 06 1995