Local No. 93-0584

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 9805837

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Elizabeth Jessie Hardy
2 SEX: female
3a TIME OF DEATH: 3:33 P.M.
3b DATE OF DEATH (Month, Day, Yr): August 2, 1993
4 SOCIAL SECURITY NUMBER: 271-26-7306
5a AGE—Last Birthday (Years): 74
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day Yr): April 8, 1919
7 BIRTHPLACE (City and State or Foreign Country): Webster Co Miss.
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: none
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
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): Clarence Hardy
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Cook
12b KIND OF BUSINESS/INDUSTRY: Church
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2557 E. 22nd Ave
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (Mexican, Puerto Rican, etc.): ☒ No ☐ Yes (If yes, specify Cuban, ...)
16 RACE—American Indian, Black, White, etc (Specify): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): 5

PARENTS

18 FATHER'S NAME (First Middle Last): Robert Willis
19 MOTHER'S NAME (First Middle Maiden Surname): Charity Scott

INFORMANT

20a INFORMANT'S NAME (Type/Print): Clarence HArdy
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2557 E. 22nd Ave Gary, In. 46407
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): August 5, 1993 Evergreen Memorial Park
21c LOCATION—City or Town, State: Hobart, In.
22a EMBALMER'S NAME: Rev. Diane E. Weems
22b EMBALMER'S LICENSE NO: FDE 0-100-151-0
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Rev Diane E. Weems
24b LICENSE NUMBER (of Licensee): FDE 0-100-151-0
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Andrew Smith Funeral Home, Inc 934 E. 21st Ave. Gary, In. 46 8300250

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. Carcinoma of the liver — Approximate Interval Between Onset and Death: 6 mos
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 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): ----

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: Harold Bornstein MD
29c MEDICAL LICENSE NO: 0101 6449
29d DATE SIGNED (Month, Day, Yr): 8/3/93

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEMS 26) (Type/Print): 3290 Grant St Gary IN 46418
31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month, Day, Year): AUG 04 1993

CORONER USE ONLY

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, ... etc:

FILED SEP 5 1995 SAM ORLICH AUDITOR LAKE COUNTY

000219

Kept # 46-0553-11