

4312 W 20th Ave
Gary IN 46404

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

4cc

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 95-0611

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

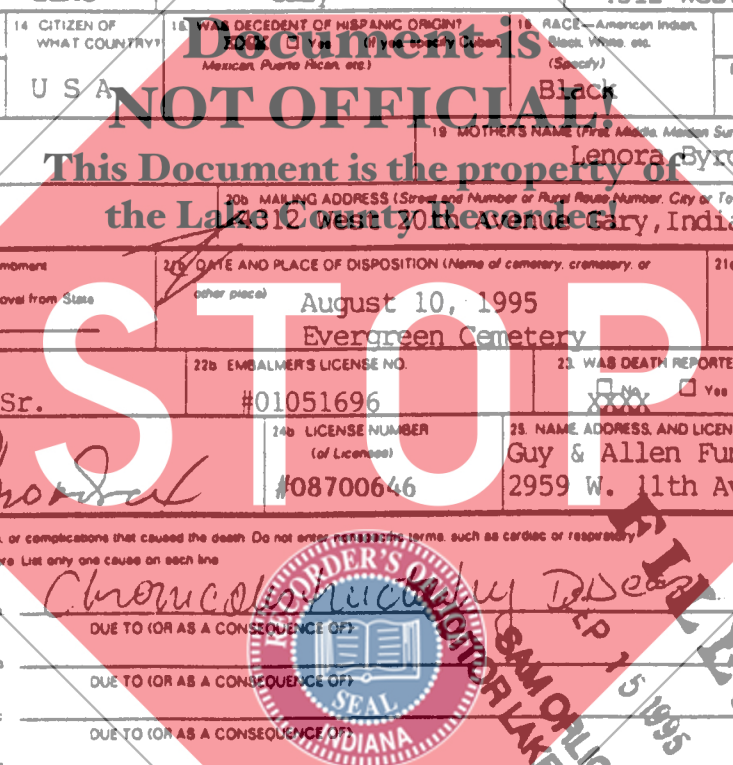
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Excell Cox		2 SEX Male	3a TIME OF DEATH 4:30 P.	3b DATE OF DEATH (Month Day Year) August 5, 1995
4 SOCIAL SECURITY NUMBER 409-34-3301	5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) January 5, 1918
7 BIRTHPLACE (City and State or Foreign Country) Charleston, Mississippi	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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 4312 West 20th Avenue		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 Grigsby	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Carpenter		12b KIND OF BUSINESS/INDUSTRY Blaw Knox Foundry
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 4312 West 20th Avenue	
13a ZIP CODE 46404	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S A	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		18 FATHER'S NAME (First Middle Last) Anniac Cox		
19 MOTHER'S NAME (First Middle Maiden Surname) Lenora Byrd		20a INFORMANT'S NAME (Type/Print) Helen Cox		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4312 West 20th Avenue Gary, Indiana 46404		20c Relationship Wife		
21 METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation		21a DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 10, 1995 Evergreen Cemetery		21b LOCATION—City or Town, State Hobart, Indiana
22a EMBALMER'S NAME Roosevelt Allen Sr.		22b EMBALMER'S LICENSE NO. #01051696		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Brodard</i>		24b LICENSE NUMBER (of Licensee) #08700646		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404
26 PART I Enter the disease, injuries, or complications that caused the death. Do not enter certifying 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) Chronic coronary artery disease DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE, listing the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
27 WAS DECEDENT PREGNANT OR SO 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)
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> IDENTIFYING 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>Dr. Harsh Dalal</i>		29c MEDICAL LICENSE NO. 29392		29d DATE SIGNED (Month Day Year) 8/11/95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Harsh Dalal M D 5820 Broadway Merrillville, Indiana 46410				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month Day Year) AUG 16 1995
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Did not be determined		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) 000980 900		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		



STATE OF INDIANA
LAKE COUNTY
FILED
SEP 15 1995
REC'D