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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1475-93

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-9

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Sallie Mae Jones
2. SEX: Female
3a. TIME OF DEATH: 12:10A M
3b. DATE OF DEATH (Month, Day, Yr): May 23, 1993
4. SOCIAL SECURITY NUMBER: 353-24-4673
5a. AGE—Last Birthday (Years): 60
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): January 26,1933
7. BIRTHPLACE (City and State or Foreign Country): Westpoint,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 XX Inpatient; ☐ ER/Outpatient; ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Claude Jones
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 2573 West 19th Avenue
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Willie James White
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Griffin

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Claude Jones
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2573 W. 19th Avenue Gary,Indiana 46404
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 28, 1993 Evergreen Cemetery
21c. 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? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Allen Broadus
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

CAUSE OF DEATH

26. PART I. Enter the disease, 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. Metastatic Carcinoma of Breast — Approximate Interval Between Onset and Death: 2 Mos.

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

Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

RECORDER'S OFFICE SEAL INDIANA

FILED

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Brain Metastases 4/93 Seizures, Septicemia

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):

SEP 26 1995

MARY E. BERRY RECORDER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

95 SEP 26 AM 11:46

SAM ORLICH AUDITOR LAKE COUNTY

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) and manner as stated. ☐ PRONOUNCING AND CERTIFYING PHYSICIAN - 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. XX 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: Barbara L. Fuller, M.D. LAKE COUNTY HEALTH COMMISSIONER
29c. MEDICAL LICENSE NO.: 0103470 1
29d. DATE SIGNED (Month, Day, Year): 5/27/93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Barbara L. Fuller, M.D. 3229 Broadway Gary, IN 46409

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): June 4, 1993

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

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SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER-PD 1