*AFFIRMATION STATE: Disclosure of the ... [illegible]

Local No. 94-346

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. men-46410 8

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

Burke-murphy 5585 Burney

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Dorris Harvey
2. SEX	Male
3a. TIME OF DEATH	5:12 AM
3b. DATE OF DEATH (Month Day Yr)	November 1, 1994
4. SOCIAL SECURITY NUMBER	425-30-3037
5a. AGE—Last Birthday (Years)	70
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Jan. 25, 1924
7. BIRTHPLACE (City and State or Foreign Country)	Winona, Mississippi
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	----
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Catherine Hospital
9c. CITY, TOWN OR LOCATION OF DEATH	East Chicago
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Margaret Short
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Steel Worker (Retired)
12b. KIND OF BUSINESS/INDUSTRY	Inland Steel
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	East Chicago
13d. STREET AND NUMBER	3901 Grand Blvd.
13e. ZIP CODE	46312
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?	[X] 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) / College (1-4 or 5+)	12th Grade

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	John Harvey
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Dovie King

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Darrise Nance
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	5341 Grant St. Merrillville, Indiana
20c. Relationship	Daughter

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	November 5, 1994 Fern Oaks Cemetery
21c. LOCATION—City or Town, State	Griffith, Indiana
22a. EMBALMER'S NAME	Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO.	FD08600238
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Tracy Cheri Williams (signature)
24b. LICENSE NUMBER (of Licensee)	FD08600238
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Hinton-Williams Funeral Home FH830015? 4859 Alexander Ave. East Chicago, In.

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Pulmonary edema	
DUE TO (OR AS A CONSEQUENCE OF) b.	Myocardial insufficiency	
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 related to Part I: Nephrotic syndrome; peripheral vascular disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
no	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
(signature)	0101 5357	11/1/94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Ronald R. Reed M.D. 3641 Ridge Rd. Highland, Indiana 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
(signature) MD.	11/03/94

Field	Entry
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	001134
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.	

FILED OCT 19 1995 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 OCT 19 AM 10: MARGARET R... RECORDER

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