

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 2024-93

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

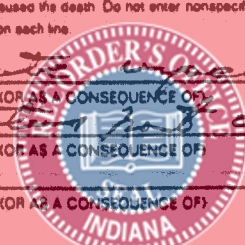
CERTIFIER

HEALTH
OFFICER

| | | | | | |
|--|--|--|--|---|--|
| 1 DECEASED—NAME (First, Middle, Last) HENRY NEWTON LONG | | 2 SEX MALE | 3a TIME OF DEATH 10:10 P.M. | 3b DATE OF DEATH (Month, Day, Year) AUGUST 16, 1993 | |
| 4 SOCIAL SECURITY NUMBER 311-12-3236 | 5a AGE—Last Birthday (Years) 69 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Mo, Day, Yr) July 18, 1924 | |
| 7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana | 8a WAS DECEDENT A U.S. VETERAN? Yes | 8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946 | 9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | |
| 9b FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL | | 9c CITY, TOWN OR LOCATION OF DEATH MUNSTER | 9d COUNTY OF DEATH LAKE | | |
| 10 MARITAL STATUS (Specify) Married | 11 SURVIVING SPOUSE (If wife, give maiden name) Bernadette E. Smith | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired!) Warehouseman | 12b KIND OF BUSINESS/INDUSTRY Gary Housing Authority | | |
| 13a RESIDENCE—STATE Indiana | 13b COUNTY Lake | 13c CITY, TOWN OR LOCATION Gary | 13d STREET AND NUMBER 1925 Monroe Lane | | |
| 13e ZIP CODE 46407 | 13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <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) 2 Years College (11-4 or 5+) |
| 18 FATHER'S NAME (First, Middle, Last) Henry Mitchell Long | | 19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary Alice Bell | | | |
| 20a INFORMANT'S NAME (Type/Print) Bernadette E. Long | | 20b MAILING ADDRESS (Street, Rural Route Number, City or Town, State, Zip Code) 1925 Monroe Lane, Gary, Indiana 46407 | | 20c Relationship Wife | |
| 21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) August 21, 1993 Oak Hill Cemetery | | 21c LOCATION—City or Town, State Gary, Indiana | |
| 22a EMBALMER'S NAME Roosevelt Allen Sr. | | 22b EMBALMER'S LICENSE NO. #01051696 | 23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</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 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) Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF) Coronary atherosclerosis DUE TO (OR AS A CONSEQUENCE OF) Diabetes mellitus PART II: Other significant conditions contributing to death but not previously stated in Part I Diabetes mellitus | | | | | |
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No | | 28a WAS AN AUTOPSY PERFORMED? (Yes or no) No | | 28b TIME AUTOPSY BEGAN TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 4 5 | |
| 29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING 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>[Signature]</i> | | 29c MEDICAL LICENSE NO. 19251 | |
| 29d DATE SIGNED (Month, Day, Year) AUGUST 17, 1993 | | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. FRED ADLER, M. D. 800 MACARTHUR BLVD. MUNSTER, INDIANA 46321 | | | |
| 31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> | | 32 DATE FILED (Month, Day, Year) Aug 23, 1993 | | | |
| 33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 34a DATE OF INJURY (Month, Day, Year) | 34b TIME OF INJURY | 34c INJURY AT WORK? (Yes or no) | 34d DESCRIBE HOW INJURY OCCURRED 001782 |
| 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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SAM ORLICH AUDITOR OF LAKE COUNTY

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