3C4 195110

INDIANA STATE BOARD OF HEALTH

Local No. 2181-92 CERTIFICATE OF DEATH State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Lillian Shipp
2 SEX: female
3a TIME OF DEATH: 3:30a M
3b DATE OF DEATH (Month, Day, Yr): October 17, 1992
4 SOCIAL SECURITY NUMBER: 317-20-5386
5a AGE—Last Birthday (Years): 91
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr): Aug. 10, 1901
7 BIRTHPLACE (City and State or Foreign Country): Coosada, Alabama
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): Munster Med Inn
9c CITY, TOWN OR LOCATION OF DEATH: Munster
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Widowed
11 SURVIVING SPOUSE (If wife, give maiden name): None
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Seamstress
12b KIND OF BUSINESS/INDUSTRY: Self-Employed
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1740 Carolina Street
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS? ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc. (Specify): Afro Amer
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

46-65-11

PARENTS

18 FATHER'S NAME (First, Middle, Last): George Wesley Sherrell
19 MOTHER'S NAME (First, Middle, Maiden Surname): Annie Day Head

INFORMANT

20a INFORMANT'S NAME (Type/Print): Davita R. Shipp
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11701 State St., Calumet City, IL 60409
20c RELATIONSHIP: Granddaughter

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 22, 1992 Oakhill Cemetery
21c LOCATION—City or Town, State: Gary, Indiana

22a EMBALMER'S NAME: Sherman G. Banks III
22b EMBALMER'S LICENSE NO.: FDE 1016254
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FDO 1042607
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner, Inc. 4209 Grant St., Gary, Indiana 46408 FDH8990001

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): Acute arrhythmia with cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF): Chronic Atrial Fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death

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: Bronchiectasis Fracture(L) ankle

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) and manner 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: [signature], MD
29c MEDICAL LICENSE NO.: IN 20248
29d DATE SIGNED (Month, Day, Year): 10/19/92

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): W.V. HEHEMANN, M.D. 2304 CALUMET AVE MUNSTER, IN 46321
31 HEALTH OFFICER'S SIGNATURE: [signature], M.D.
32. DATE FILED (Month, Day, Year): Oct 20, 1992

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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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1