

700
3 years
Local No. 4852-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

PARENTS
INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

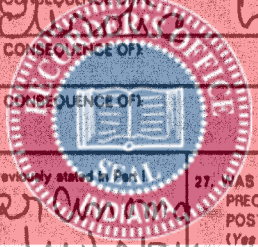
CORONER
USE ONLY

1. DECEASED—NAME (First, Middle, Last) J. C. Brown				2. SEX Male		3a. TIME OF DEATH 2:00a		3b. DATE OF DEATH (Month, Day, Year) December 10, 1989	
4. SOCIAL SECURITY NUMBER 427 03 1544		5a. AGE—Last Birthday (Years) 67		5b. UNDER 1 YEAR Months: Days		5c. UNDER 1 DAY Hours: Minutes		6. DATE OF BIRTH (Mo, Day, Yr) July 2, 1922	
7. BIRTHPLACE (City and State or Foreign Country) Little Rock, Ark.		8a. WAS DECEDENT A U.S. VETERAN? Yes							
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		8c. 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							
9a. FACILITY NAME (If not institution, give street and number) St. Mary's Medical Center				9b. CITY, TOWN, OR LOCATION OF DEATH Gary			9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Evelyn Bowles		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) XXXXXXXXXX Steelworker			12b. KIND OF BUSINESS/INDUSTRY XXXXXXXXXXXX USX		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary			13d. STREET AND NUMBER 2313 W. 15th Ave.		
13e. ZIP CODE 46404		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) Unknown		18. FATHER'S NAME (First, Middle, Last) Willie Brown							
19. MOTHER'S NAME (First, Middle, Maiden Surname) Roberta Brooks								20a. INFORMANT'S NAME (Type/Print) Evelyn Brown	
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2313 W. 15th Ave. Gary, IN. 46404						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) December 14, 1989 Green Cemetery			21c. LOCATION—City or Town, State Hobart Indiana				
22a. EMBALMER'S NAME Roosevelt Allen Jr.			22b. EMBALMER'S LICENSE NO. 01051701			23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24. SIGNATURE OF FUNERAL DIRECTOR <i>Willie J. Brooks</i>			24b. LICENSE NUMBER (of Licensee) 08700646			25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. Gary, In. 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. Congestive Cardiac Failure									
26. PART II: Other important conditions: Conditions contributing to death but not previously stated in Part I. Metastatic Carcinoma of Primary Kidney									
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 COMMISSION OF DEATH? (Yes or no) No									
29. 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 checked="" type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> CORONER									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rubina P. Porter</i>			29c. MEDICAL LICENSE NO. IN 21043			29d. DATE SIGNED (Month, Day, Year) 12/11/89			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Krishnan Potti, M.D., 8300 Broadway, Merr., IN 46410									
31. HEALTH OFFICER'S SIGNATURE <i>Paul...</i>							31. DATE FILED (Month, Day, Year) Dec. 19, 1989		
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			
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) 000345					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

2313 W. 15th Ave
Gary
Ind

Received by
Aged
Nov 45-28-21

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FILED
STATE OF INDIANA
LAKE COUNTY
RECORDED
NOV 11 1989
SAM ORLICH
AUDITOR LAKE COUNTY

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