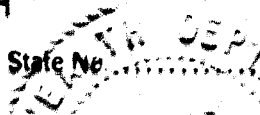


ATTENTION STATE: Disclosure of this information is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH



Local No. 95-0447

## CERTIFICATE OF DEATH

State No. \_\_\_\_\_

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (Type above last name) <b>Charles L. McNeal Sr.</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>2:29 P.M.</b>	3b DATE OF DEATH (Month, Day, Year) <b>June 11, 1995</b>
4 SOCIAL SECURITY NUMBER <b>316-09-3373</b>	5a AGE—Last birthday (Years) <b>74</b>	5b UNDER 1 YEAR (Months, Days) <b>None</b>	5c UNDER 1 DAY (Hours, Minutes) <b>None</b>	6 DATE OF BIRTH (Month, Day, Year) <b>July 15, 1920</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Atkins, Arkansas</b>	8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>None</b>	
9a FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital Northlake</b>		9b CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>		
9c COUNTY OF DEATH <b>Lake</b>		10 MARITAL STATUS <b>Married</b>		
11 SURVIVING SPOUSE (If wife, give maiden name) <b>Sirlilars Owens</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Craneman</b>		12b KIND OF BUSINESS/INDUSTRY <b>USX</b>
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Gary</b>	13d STREET AND NUMBER <b>2339 W. 15th Avenue</b>	
13e ZIP CODE <b>46404</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>Black</b>
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th</b>		18 FATHER'S NAME (First Middle Last) <b>Arthur McNeal</b>		
19 MOTHER'S NAME (First Middle Maiden surname) <b>Estelle</b>		20a INFORMANT'S NAME (Type/Print) <b>Sirlilars Mc Neal</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2339 W. 15th Avenue, Gary, Indiana 46404</b>		20c WITNESS <b>Wife</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>June 16, 1995, Fern Oak Cemetery</b>		21c LOCATION—City or Town, State <b>Griffith, Indiana</b>
22a EMBALMER'S NAME <b>Patrician Owens</b>		22b EMBALMER'S LICENSE NO. <b>08700298</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) <b>8700646</b>		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Guy &amp; Allen Funeral Directors Inc. 83007704 2959 W. 11th Avenue, Gary, Indiana 46404</b>
26 PART I: IMMEDIATE CAUSE (Type disease or condition resulting in death) <b>Metastatic Carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF) a. _____ b. _____ c. _____ d. _____				
PART II: Other significant conditions - Conditions contributing to death but not previously listed in Part I				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
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. <b>01033371</b>	29d DATE SIGNED (Month, Day, Year) <b>June 16, 1995</b>
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>111 E. 5th Ave. Gary, Indiana 46404 Dr. Michael Kovacich</b>				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE SIGNED (Month, Day, Year) <b>JUN 21 1995</b>
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Cause not determined		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street, Rural Route Number, City or Town, State) <b>NOV 8 1995</b>		
35 DATE PRONOUNCED DEAD (Month, Day, Year)		36 MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify date and location		



STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORDER  
NOV 28 AM 9:28  
CLERK OF CLERK AND RECORDER

key # 45-28-1

FILED  
SAM O'FLICH  
AUDITOR LAKE COUNTY

000381

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