

ATTENTION ESTATE: Disclosure of the fact that we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Lucas, Holcomb & Medina
300 W. 90th Dr.
Merrill, Mo. 64540

Local No. 95-0117

State No. 46-110

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Clifton Key		2 SEX Male	3 TIME OF DEATH 2:13pm	4 DATE OF DEATH (Month Day Yr) January 30, 1995
5 SOCIAL SECURITY NUMBER 312-30-4329	6a AGE—Last Birthday (Years) 71	6b UNDER 1 YEAR Months Days	6c UNDER 1 DAY Hours Minutes	7 DATE OF BIRTH (Mo Day Yr) September 5, 1923
8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		

DECEASED

9b FACILITY NAME (If not institution give street and number) Methodist Hospital Northlake		9c CITY TOWN OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ethel Osborne	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Master Mechanic	12b KIND OF BUSINESS/INDUSTRY Steel City Ford
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 3623 West 23rd Avenue

PARENTS

13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) <input type="checkbox"/> College (1-4 or 5+) 3 Years
18 FATHER'S NAME (First Middle Last) Winston Key		19 MOTHER'S NAME (First Middle, Maiden Surname) Cornelia (Unknown)			

INFORMANT

20a INFORMANT'S NAME (Type/Print) Ethel Key	20b MAKING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 West 23rd Avenue Gary, Indiana 46404	20c Relationship Wife
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DISPOSITION

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 (City or Town, State, Zip Code) February 6, 1995 Evergreen Cemetery	21c LOCATION—City or Town Hobart, Indiana
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22a EMBALMER'S NAME Roosevelt Allen Sr.	22b EMBALMER'S LICENSE NO. 01051696	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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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 West 11th Avenue Gary, Indiana 46404
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CAUSE OF DEATH

26 PART I: Enter the immediate cause of death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction	Approximate Interval Between Onset and Death 10
IMMEDIATE CAUSE (Final disease or condition resulting in death)	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	
a DUE TO (OR AS A CONSEQUENCE OF)	
b DUE TO (OR AS A CONSEQUENCE OF)	
c DUE TO (OR AS A CONSEQUENCE OF)	
d DUE TO (OR AS A CONSEQUENCE OF)	

PART II Other significant conditions - Conditions contributing to death but not proximately causing it (Part I)	27 WAS DECEDENT PREGNANT (Specify trimester, postpartum) (Yes or no) NO	28a WAS AN AUTOPSY PERFORMED (Yes or no) NO	28b WERE AUTOPSY FINDINGS AVAILABLE FOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO
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CERTIFIER

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.
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29b SIGNATURE AND TITLE OF CERTIFIER C. B. [Signature], M.D.	29c MEDICAL LICENSE NO. IL, 036-067609	29d DATE SIGNED (Month, Day, Year) 2/8/95
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HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Eugene Banks, M.D., 9330 Broadway Crown Point, Ind	32 DATE FILED (Month, Day, Year) FEB 10 1995
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>	

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"/> 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) 000123	

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 900
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CK# 08477 SK

Wildwood Sub 10175
Key # 47-401-21
Unit # 25



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MARGARET L. BENDER
95 NOV - 6
NOV 10 1995