* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 95-0613

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. Angela Carroll P.O. Box 6416 Gary In. 46406

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): Marie CARROLL
2. SEX: Female
3a. TIME OF DEATH: 2:08AM
3. DATE OF DEATH (Month Day Year): July 30, 1995
4. SOCIAL SECURITY NUMBER: 286-30-7975
5a. AGE - Last Birthday (Years): 63
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): Apr 3, 1932
7. BIRTHPLACE (City and State or Foreign Country): Wynne, AR 72396
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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist 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): Roosevelt Carroll
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steel Worker
12b. KIND OF BUSINESS INDUSTRY: Manufacturing
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 1300 Ralston Street
13e. ZIP CODE: 46406
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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+): 1

PARENTS

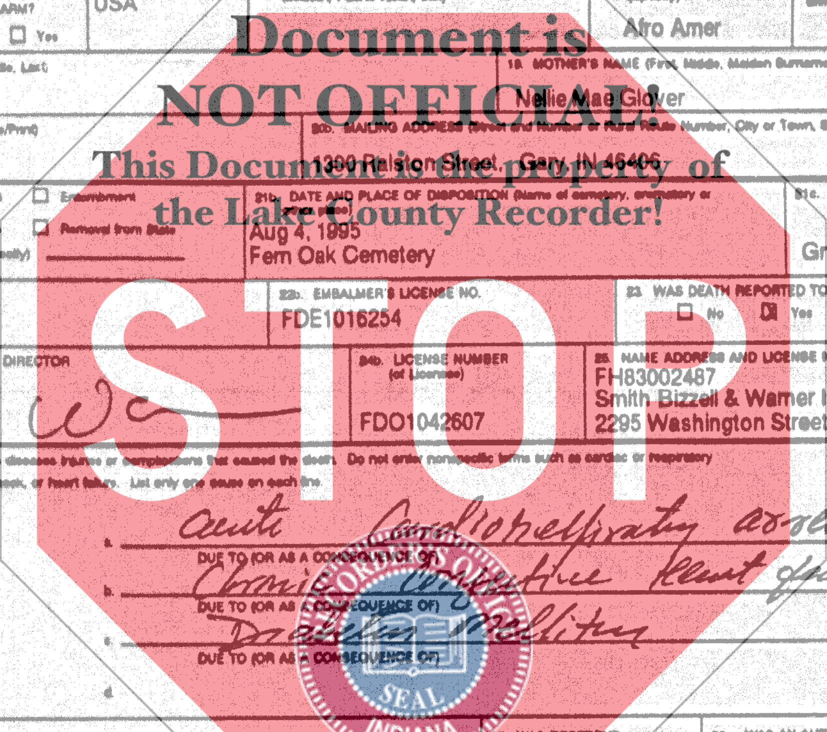
18. FATHER'S NAME (First, Middle, Last): Obie Hare
19. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Mae Glover

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Roosevelt Carroll
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1300 Ralston Street, Gary, IN 46406
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Aug 4, 1995 Fern Oak Cemetery
21c. LOCATION - City or Town State: Griffith, IN
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO1042607
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83002487 Smith Bizzell & Warner Inc. 2295 Washington Street, Gary, IN 46407


Document is NOT OFFICIAL! This Document is the property of the Lake County Recorder!
STOP

95 AUG -9 AM 10:00
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
MARGARET [illegible] RECORDER

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. acute Cardiorespiratory arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Chronic Congestive Heart failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF)
d.

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 listed in Part I: Chronic renal failure
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): 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) 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]
29c. MEDICAL LICENSE NO: 01026051
29d. DATE SIGNED (Month Day Year): 8/04/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Vijay Dave, 3229 Broadway, Gary, IN 46407

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month Day Year): AUG 08 1995
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): 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.: No

SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCERPD 1

cs. 900 Jk.