90-0694 bcc

Local No. ....

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1 DECEASED—NAME (First Middle Last): LES SLAUGHTER
- 2 SEX: MALE
- 3a TIME OF DEATH: 1:36p M
- 3b DATE OF DEATH (Month Day Yr): SEP. 21ST, 1990
- 4 SOCIAL SECURITY NUMBER: 425-01-[redacted] 2016
- 5a AGE—Last Birthday (Years): 78
- 5b UNDER 1 YEAR: Months / Days
- 5c UNDER 1 DAY: Hours / Minutes
- 6 DATE OF BIRTH (Mo. Day Yr): APR. 16, 1911
- 7 BIRTHPLACE (City and State or Foreign Country): PHILADEPHIA, MS.
- 8a WAS DECEDENT A U.S. VETERAN?: NO
- 8b YEAR LAST SERVED IN U.S. ARMED FORCES?: NONE
- 9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
- 9b FACILITY NAME (If not institution, give street and number): ST. MARY'S MEDICAL CENTER
- 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): VERSIE
- 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): LABORER
- 12b KIND OF BUSINESS/INDUSTRY: STEEL MILL
- 13a RESIDENCE—STATE: INDIANA
- 13b COUNTY: LAKE
- 13c CITY, TOWN, OR LOCATION: GARY
- 13d STREET AND NUMBER: 2059 ROOSEVELT PL
- 13e ZIP CODE: 46404
- 13f INSIDE CITY LIMITS: ☐ No [X] Yes
- 13g ON A FARM?: [X] No ☐ Yes
- 14 CITIZEN OF WHAT COUNTRY?: U S A
- 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No ☐ Yes
- 16 RACE—American Indian, Black, White, etc. (Specify): BLACK
- 17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH; College (1-4 or 5+)

PARENTS

- 18 FATHER'S NAME (First Middle Last): LOUIS SLAUGHTER
- 19 MOTHER'S NAME (First Middle Maiden Surname): INEZ CARTER

INFORMANT

- 20a INFORMANT'S NAME (Type/Print): VERSIE SLAUGHTER
- 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2059 ROOSEVELT PL. GARY, IN. 46404
- 20c Relationship: WIFE

DISPOSITION

- 21a METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
- 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEP. 25TH, 1990 FERN OAKS CEMETERY
- 21c LOCATION—City or Town, State: GRIFFITH, IN.
- 22a EMBALMER'S NAME: CELESTE P. KAUFMAN
- 22b EMBALMER'S LICENSE NO.: FDE: 1033626
- 23 WAS DEATH REPORTED TO CORONER?: [X] No ☐ Yes
- 24a SIGNATURE OF FUNERAL DIRECTOR: Celeste P. Kaufman
- 24b LICENSE NUMBER (of Licensee): FDH: 3002411
- 25 NAME AND ADDRESS OF FUNERAL HOME: KAUFMAN FUNERAL HOME INC. 421 WEST 5TH AVE. GARY INDIANA 46402 FDH: 3002411

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)

a. Respiratory Failure

DUE TO (OR AS A CONSEQUENCE OF):

b. Chronic obstructive pulmonary disease

DUE TO (OR AS A CONSEQUENCE OF):

c. Bronchitis

DUE TO (OR AS A CONSEQUENCE OF):

d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

- 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)

- [X] 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.: 01032180
- 29d DATE SIGNED (Month, Day, Year): 9/28/90
- 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. SURENDRA SHAH M.D., 1110 W. 5TH AVE. GARY, IN. 46402 (219)882-0255

HEALTH OFFICER

- 31 HEALTH OFFICER'S SIGNATURE: [signature] MD
- 32 DATE FILED (Month, Day, Year)

CORONER USE ONLY

- 33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)
- 34g DATE PRONOUNCED DEAD (Month, Day, Year)
- 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED

NOV 13 1995

SAM ORLICH

AUDITOR LAKE COUNTY

000790

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

95 NOV 13 AM 10:22

MARGIE CLERK RECORDER

95069055

Key# 46-48-33

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