91-0897

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. ....

State No. 11

300 W ... Gary 46408

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Olando Charleston Sr.
2 SEX: Male
3a TIME OF DEATH: 11:59P
3b DATE OF DEATH (Month Day Yr): December 2, 1991
4 SOCIAL SECURITY NUMBER: 428-44-6827
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): MAY 21, 1928
7 BIRTHPLACE (City and State or Foreign Country): Edwards, Mississippi
8a WAS DECEDENT A US VETERAN?: No
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): 862 Tennessee Street
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): Valerie R. Boston
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Locomotive Engineer
12b KIND OF BUSINESS/INDUSTRY: USX Steel Corp.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 862 Tennessee Street
13e ZIP CODE: 46402
13f INSIDE CITY LIMITS: ☐ No ☐ Yes
13g ON A FARM?: ☐ No X ☐ 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 Am
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Roosevelt Charleston
19 MOTHER'S NAME (First Middle Maiden Surname): Gertrude Gordon

INFORMANT

20a INFORMANT'S NAME (Type/Print): Valerie R. Charleston
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 862 Tennessee St. Gary, Ind. 46402
20c Relationship: Wife

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): Oakhill Cemetery Dec. 9, 1991
21c LOCATION—City or Town, State: Gary, Indiana
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): FD01042607
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell Warner & Son 209 Grant St. Gary, In. 46408

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. Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF)
b. Severe Anemia
DUE TO (OR AS A CONSEQUENCE OF)
c. Chronic Renal Failure
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

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: Sandra Gadson, M.D.
29c MEDICAL LICENSE NO: 01029625
29d DATE SIGNED (Month Day Year): December 5, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Sandra Gadson, 569 Tyler Street, Gary, Indiana 46402

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): DEC. 5 1991

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.

000826

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

Ct# 74918

900

44-23-21

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FILED FOR RECORD
STATE OF INDIANA LAKE COUNTY
95 NOV 13 PM 1:58
MARGARET ... RECORDER

FILED
NOV 13 1995
SAM ORLICH
AUDITOR LAKE COUNTY