

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

8cc
2vets
10total

Local No. 3190-91

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Clifford Celesta McCloud		2 SEX Male	3a TIME OF DEATH 9:30 a.m.	3b DATE OF DEATH (Month, Day, Yr) December 12, 1991	
4 SOCIAL SECURITY NUMBER 261-46-8642	5a AGE—Last Birthday (Years) 56	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) May 28, 1935	
7 BIRTHPLACE (City and State or Foreign Country) Jacksonville, FL	8a WAS DECEDENT A U.S. VETERAN? Yes				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake		9c CITY, TOWN, OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Rhoda Jackson	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pharmaceutical Rep.		12b KIND OF BUSINESS/INDUSTRY Wyeth Laboratory	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Merrillville	13d STREET AND NUMBER 615 W. 55th Avenue		
13e ZIP CODE 46410	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 4 Years		18 FATHER'S NAME (First Middle Last) Clifford McCloud			
19 MOTHER'S NAME (First Middle, Maiden Surname) Mercedes McCants		20a INFORMANT'S NAME (Type/Print) Rhoda McCloud			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 West 55th Ave, Merrillville, IN, 46410		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) DECEMBER 17, 1991 Evergreen Memorial Park		21c LOCATION—City or Town, State Hobart, Indiana	
22a EMBALMER'S NAME Roosevelt Allen Jr.		22b EMBALMER'S LICENSE NO. 01051701	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie J. Swanson</i>		24b LICENSE NUMBER (of Licensee) 08700646	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Ave Gary, IN 46404 83007704		
26 PART I Enter the disease, 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) Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS WHICH GIVE RISE TO THE IMMEDIATE CAUSE, stating the underlying cause last DEC 20 1991 DUE TO (OR AS A CONSEQUENCE OF) PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I (1) Ascending Cholangitis (2) Biliary tract obstruction					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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 checked="" 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 Barbara L Fuller, M.D.		29c MEDICAL LICENSE NO. 01034701	29d DATE SIGNED (Month, Day, Year) 12/16/91		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) BARBARA L. FULLER 3229 BEDFORDWAY, GARY, IN 46408					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander J Williams M.D.</i>				32 DATE FILED (Month, Day, Year) December 20, 1991	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

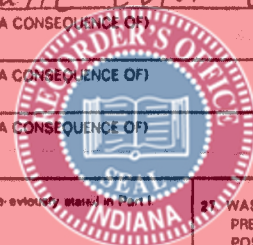
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

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



STATE OF INDIANA LAKE COUNTY FILED NOV 17 1991 SAM ORLICH AUDITOR LAKE COUNTY

Key # 15-256-26

960 CS #3