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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 3190-91 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

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 US VETERAN?: Yes
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): 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 DECEDENT'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: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U S A
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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); College (1-4 or 5+): 4 Years

PARENTS

18 FATHER'S NAME (First, Middle, Last): Clifford McCloud
19 MOTHER'S NAME (First, Middle, Maiden Surname): Mercedes McCants

INFORMANT

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

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): 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?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Valerie [signature]
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors, Inc 2959 West 11th Ave Gary, IN 46404

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): Metastatic Colon Cancer — Approximate Interval Between Onset and Death: 5 months
DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
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
28a WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

Key # 15-256-26

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: 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 BROADWAY, GARY, IN 46408

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S Williams MD
32 DATE FILED (Month, Day, Year): December 20, 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.

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

[Stamps:] LAKE COUNTY HEALTH COMMISSIONER; COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY; DEC 20 1991; FILED NOV 17 1998 SAM ORLICH AUDITOR LAKE COUNTY; STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 98 NOV 17 PM 3:46 MARGARET LEVENSELLER RECORDER; 98076498

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