

Subscribed and sworn to before me this 18th day of October,
1995.

Rosalind G. Parr

ROSALIND G. PARR, Notary Public
Lake County Resident

My Commission Expires:
September 22, 1997

**Document is
NOT OFFICIAL!**

**This Document is the property of
the Lake County Recorder!**

This document was prepared by Rosalind G. Parr, Attorney at Law,
8315 Virginia Street, Suite 7, Merrillville, IN 46410

STOP



93-0969

INDIANA STATE DEPARTMENT OF HEALTH

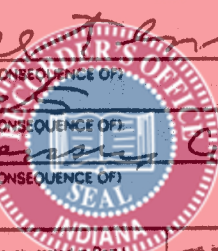
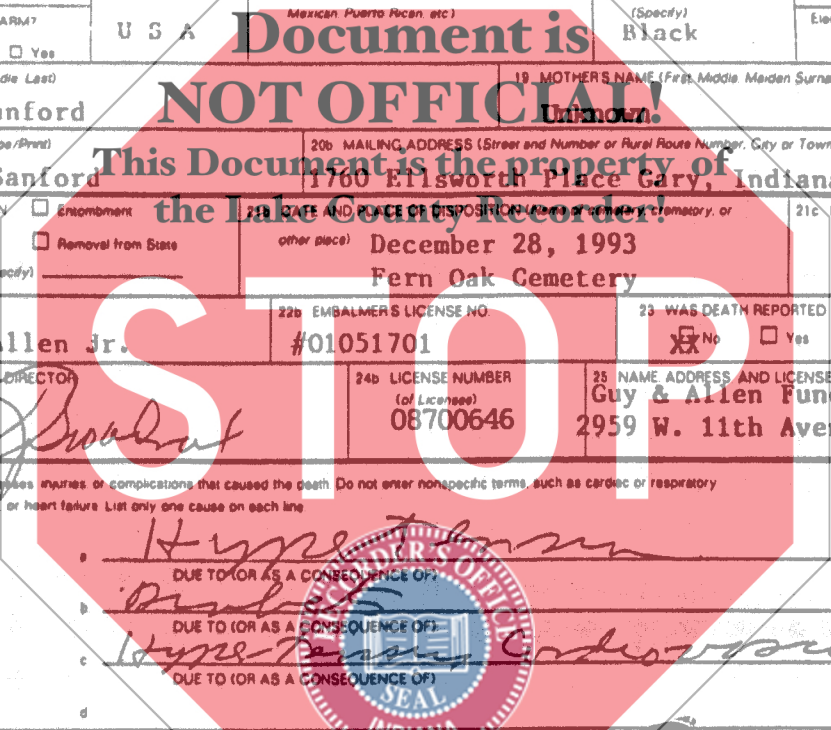
CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Reuben Lee Sanford		2 SEX Male	3a TIME OF DEATH 4:00 A.M.	3b DATE OF DEATH (Month Day Yr) December 22, 1993
4 SOCIAL SECURITY NUMBER 314-22-5637	5a AGE—Last Birthday (Years) 66	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) October 28, 1927
7 BIRTHPLACE (City and State or Foreign Country) Indiana	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? Unknown	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> NOA <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 1760 Ellsworth Place		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) Geraldine Hester	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker		12b KIND OF BUSINESS/INDUSTRY Bethlehem Steel
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 1760 Ellsworth Place	
13a ZIP CODE 46404	13a INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S A	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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years		18 FATHER'S NAME (First Middle Last) Lewis Sanford		
19 MOTHER'S NAME (First Middle Maiden Surname) Unknown		20a INFORMANT'S NAME (Type/Print) Geraldine Sanford		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1760 Ellsworth Place Gary, Indiana 46404		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Date, cemetery, crematory, or other place) December 28, 1993 Fern Oak Cemetery	21c LOCATION—City or Town, State Griffith, 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>Cheryl Probst</i>	24b LICENSE NUMBER (of Licensee) 08700646	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404		
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. Hypertension DUE TO (OR AS A CONSEQUENCE OF) Diabetes DUE TO (OR AS A CONSEQUENCE OF) Hypertension, Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death years years years		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Acholic		27a WAS AN AUTOPSY PERFORMED? (Yes or no) no	27b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) no	
28a 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 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.		28b SIGNATURE AND TITLE OF CERTIFIER Thomas E. Cullers AUDITOR LAKE COUNTY		
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Thomas Cullers 3290 Grant Street Gary, IN 46408		29a MEDICAL LICENSE NO. 01030748	29b DATE SIGNED (Month, Day, Year) 12/30/93	
31 HEALTH OFFICER'S SIGNATURE <i>Thomas E. Cullers</i>		32 DATE FILED (Month, Day, Year) JAN. 06 1994		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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. 001100		



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY