

8cc

Reese Price
1114 W. 81st St.
Chicago, Ill. 60620

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1957-92

State No. 60620

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1 DECEASED—NAME (First, Middle, Last) Bennie Lee Williams Sr				2 SEX Male		3a TIME OF DEATH 11:55A		3b DATE OF DEATH (Month, Day, Year) September-8, 1992			
4 SOCIAL SECURITY NUMBER 423-26-1411		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) Nov. 19, 1928		7 BIRTHPLACE (City and State or Foreign Country) Montgomery, Alabama	
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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/>				OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) None			
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) Fannie Long		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Carpenter				12b KIND OF BUSINESS/INDUSTRY Gary Community School Corporation			
13a RESIDENCE—STATE Indiana			13b COUNTY Lake		13c CITY TOWN OR LOCATION Gary			13d STREET AND NUMBER 1907 West 10th Place			
13e ZIP CODE 46404		13f 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 type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify origin)		16 RACE—American Indian, Black, White, etc. Black		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) Unknown	
18 FATHER'S NAME (First, Middle, Last) Nebraska Williams						19 MOTHER'S NAME (First, Middle, Maiden Surname) Artia Bell Johnson					
20a INFORMANT'S NAME (Type, Print) Fannie Williams				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1907 W. 10th Place Gary, IN 46404				20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) September 12, 1992 Oak Hill Cemetery				21c LOCATION—City or Town Gary, IN			
22a EMBALMER'S NAME Roosevelt Allen Sr.				22b EMBALMER'S LICENSE NO. 01051696				23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Roosevelt Allen Sr.</i>				24b LICENSE NUMBER (of Licensee) 08700646		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 8300770- Guy & Allen Funeral Directors Inc. 2959 W. 11th Ave Gary, IN 46404					
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. Prostate Cancer										THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) Prostate Cancer										NOV 30 1995	
CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last										RECORDED	
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.										STATE OF INDIANA LAKE COUNTY OFFICE OF RECORDS	
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO						28 WAS AN AUTOPSY PERFORMED? (Yes or no) NO		29 IS THIS CERTIFICATE AVAILABLE FROM TO COMPLETION OF CAUSE OF DEATH? (Yes or no)			
29a CERTIFIER <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.											
29b SIGNATURE AND TITLE OF CERTIFIER <i>Oscar De La Paz M.D.</i>						29c MEDICAL LICENSE NO. 25272		29d DATE SIGNED (Month, Day, Year) 9/15/92			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type, Print) Dr Oscar De La Paz 8679 Connecticut Merrillville, IN 46410											
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, M.D.</i>										32 DATE FILED (Month, Day, Year) Sept. 16, 1992	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined			34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY (Year)		34c INJURY AT WORK? (Yes or no)		34d DESCRIBE HOW INJURY OCCURRED FILED		
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 30 1995						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. SAM ORLICH AUDITOR LAKE COUNTY							

Unit # 35
Key # 50-139-6 to 16
A.S.H. & Inv Co's Add to Liverpool All lots 6 to 16 Block 8

CS. 9.06