ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

2CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 95-0844 State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Myrtle E. Lowe
2. SEX: Female
3a. TIME OF DEATH: 10:12 PM
3b. DATE OF DEATH (Month Day Yr): November 7, 1995
4. SOCIAL SECURITY NUMBER: 314-22-7119
5a. AGE—Last Birthday (Years): 84
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo Day Yr): September 23, 1911
7. BIRTHPLACE (City and State or Foreign Country): Franklin, Kentucky
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 XXX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
9c. CITY, TOWN OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 1943 Martin Luther King Drive
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No XXX Yes
13g. ON A FARM? XXXX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? XXXX 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): 12th; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Pete Lucas
19. MOTHER'S NAME (First Middle Maiden Surname): Anna Moss Hall

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Juanita Dinwiddie
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1548 Wilson Street Gary, Indiana 46404
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): November 11, 1995 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO: #01051696
23. WAS DEATH REPORTED TO CORONER? XXXX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
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 FH8300770

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. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Cor Pulmonale
DUE TO (OR AS A CONSEQUENCE OF)
c. Emphysema
DUE TO (OR AS A CONSEQUENCE OF)
d. Arteriosclerotic Heart Disease

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 stated 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): ---------

CERTIFIER

29a. CERTIFIER (Check only one): XXX 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: [signature] Cannon MD
29c. MEDICAL LICENSE NO: IN 01032499
29d. DATE SIGNED (Month, Day, Year): 11/13/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Cannon 1619 West 5th Avenue Gary, Indiana 46402

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): NOV 17 1995

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.

FILED FEB 12 1996 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 96 FEB -1 ... MARION ... RECORDER

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Key # 47-432-10

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1