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

6cc

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 96-0084 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): John T. Brandon Sr.			2 SEX: Male		3a TIME OF DEATH: 9:35 PM	3b DATE OF DEATH (Month Day Yr): February 6, 1996
4 SOCIAL SECURITY NUMBER: 430-30-6971	5a AGE—Last Birthday (Years): 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr): July 26, 1925		7 BIRTHPLACE (City and State or Foreign Country): Arkansas
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 ☒ 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: Married	11 SURVIVING SPOUSE (If wife, give maiden name): Versie Scott		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Hand Bander		12b KIND OF BUSINESS/INDUSTRY: LTV Steel Corp.	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY TOWN OR LOCATION: Gary		13d STREET AND NUMBER: 4407 West 20th Place		
13e ZIP CODE: 46404	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): 7th	College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Charlie Brandon	19 MOTHER'S NAME (First Middle Maiden Surname): Bammer Cooks

INFORMANT

20a INFORMANT'S NAME (Type/Print): Versie Brandon	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4407 West 20th Place Gary, Indiana 46404	20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): February 13, 1996 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? ☒ 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. N83007704 2959 West 11th Avenue Gary, Indiana 46404

9601067

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. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Metastatic Cancer of Prostate
DUE TO (OR AS A CONSEQUENCE OF)
d.

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)

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
96 FEB 15 PM 3:0?
MARSHA ... RECORDER

Tarrytown 1st Sub Lot 6 Block 6
Key #47-442-6
Unit #25

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: [signature]	29c MEDICAL LICENSE NO: 01032180	29d DATE SIGNED (Month Day Year): 2/12/96

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Surendra Shah 5825 Broadway Suite A Merrillville, Indiana 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): FEB 15 1996

FILED

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.

FEB 15 1996
SAM ORLICH
AUDITOR LAKE COUNTY

000820 900 SU

CS

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