

ATTENTION ESTATE: Disclosure of the fact that we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

95-0722

Local 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) FRANK NEWTON FORD		2 SEX MALE	3a TIME OF DEATH 6:18p	3b DATE OF DEATH (Month, Day, Yr.) SEPTEMBER 18, 1995	
4 *SOCIAL SECURITY NUMBER 439-07-0666	5a AGE—Last Birthday (Years) 81	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) MAY 15, 1914	
7 BIRTHPLACE (City and State or Foreign Country) WEYNAHOKE, LOUISIANA	8a WAS DECEDENT A U.S. VETERAN? NO				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9a FACILITY NAME (If not institution, give street and number) NORTHWEST FAMILY		9b CITY, TOWN OR LOCATION OF DEATH GARY	9c COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) BERTHA MAE	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) LONG SHOREMAN	12b KIND OF BUSINESS/INDUSTRY LOADER FOR SHIPS		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION GARY	13d STREET AND NUMBER 2265 PENNSYLVANIA ST.		
13e ZIP CODE 46407	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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) BLK.	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th.	College (1-4 or 5+) 9501874				
18 FATHER'S NAME (First, Middle, Last) LEON FORD		19 MOTHER'S NAME (First, Middle, Maiden Surname) ELLEN SMITH			
20a INFORMANT'S NAME (Type/Print) BERTHA MAE FORD		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2265 PENNSYLVANIA GARY, IND. 46407	20c Relationship WIFE		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) SEPTEMBER 23, 1995 EVERGREEN MEMORIAL PARK		21c LOCATION—City or Town, State HOBART, INDIANA	
22a EMBALMER'S NAME JOHN V. HOWER		22b EMBALMER'S LICENSE NO. 8600 440	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>John V. Hower</i>		24b LICENSE NUMBER (of Licensee) 014618	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME HOWER FUNERAL HOME 3002518 1628 WASHINGTON ST. GARY, IND.		
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Vascular collapse b. Due to arteriosclerotic heart and vascular disease c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF)					
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)	
29a. CERTIFIER (Check only one) <input 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 checked="" type="checkbox"/> DEPUTY 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>Deputy Coroner</i>		29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month, Day, Year) September 20,		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Sam Orlich</i>			32. DATE FILED (Month, Day, Year) SEP 20 1995		
33. MANNER OF DEATH <input checked="" 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) MAR 22 1996	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED MAR 22 1996
34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) SAM ORLICH AUDITOR LAKE COUNTY			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9501874		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) September 18, 1995		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 1236			

DECEDENT

PARENTS

INFORMANT

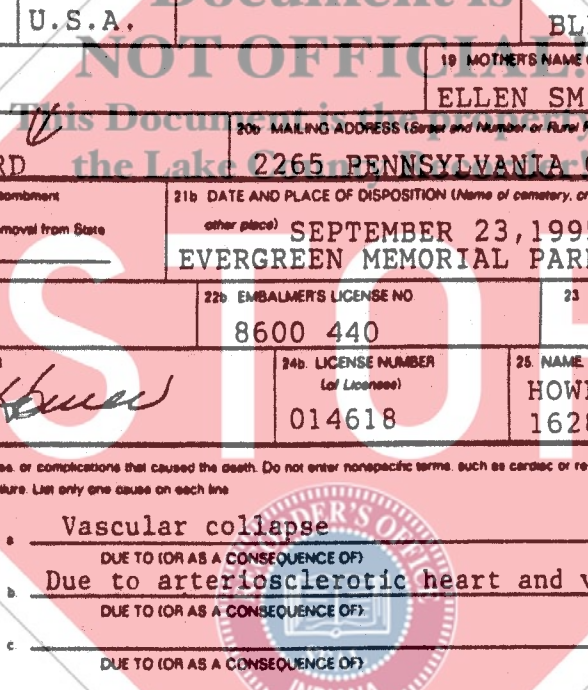
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

un. # 25
key # 46-26-4
Mid City Realty Co's Central Sub



STATE OF INDIANA
LAKE COUNTY
RECORDER
SEP 22 PM 1:27
MARGARET CLAYTON