INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 90-0107   State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Deceased—Name (First, Middle, Last)	Mary Louise Chandler
2. Sex	female
3a. Time of Death	11:10A M
3b. Date of Death (Month Day Yr)	February 2, 1990
4. Social Security Number	421-40-9072 A
5a. Age—Last Birthday (Years)	57
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo. Day Yr)	December30,1932
7. Birthplace (City and State or Foreign Country)	Opelika, Alabama
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in U.S. Armed Forces?	Never
9a. Place of Death (Check only one. See instructions)	HOSPITAL: XXXXXX Inpatient; ☐ ER/Outpatient; ☐ DOA; OTHER: ☐ Nursing Home; ☐ Residence; ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	St. Mary Medical Center
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)	Qualice Chandler
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	Clerk
12b. Kind of Business/Industry	Assesors Office
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town or Location	Gary
13d. Street and Number	727 Ralston Street
13e. Zip Code	46406
13f. Inside City Limits	☐ No XXXXs
13g. On a Farm?	XXXXX ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	XXXXX ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	Afro Amer
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Value
18. Father's Name (First, Middle, Last)	Lindsey Shelton
19. Mother's Name (First, Middle, Maiden Surname)	Rosie Lee Ligon

INFORMANT

Field	Value
20a. Informant's Name (Type/Print)	Qualice Chandler
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	727 Ralston St. Gary, In. 46406
20c. Relationship	husband

DISPOSITION

Field	Value
21a. Method of Disposition	XXXXXl; ☐ Cremation; ☐ Donation; ☐ Entombment; ☐ Removal from State; ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place)	February8,1990 Evergreen Cemetery
21c. Location—City or Town, State	Hobart, Indiana
22a. Embalmer's Name	Sherman G. Banks 3rd
22b. Embalmer's License No.	FD01016254
23. Was Death Reported to Coroner?	XXXXXX ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number (of Licensee)	FD01042607
25. Name, Address, and License Number of Funeral Home	Smith Bizzell & Warner FDH3002487 2295 Washington St. Gary, In. 46407

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. Chronic Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c.
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.

Field	Value
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)	No

CERTIFIER

29a. CERTIFIER (Check only one)
XXXXXX 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.

Field	Value
29b. Signature and Title of Certifier	Charles D. Williams
29c. Medical License No.	27353
29d. Date Signed (Month, Day, Year)	2/7/90
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	Dr. Charles Williams ND 8585 Broadway Merrillville, In. 46410

HEALTH OFFICER

Field	Value
31. Health Officer's Signature	Rhea E. Foston, M.D. MPH/ac
32. Date Filed (Month, Day, Year)	FEB. 8 1990

CORONER USE ONLY

Field	Value
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.	

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

FILED
1996
SAM ORLICH
AUDITOR LAKE COUNTY 000107

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
96 APR 11 PM 1:14
MARIE ... RECORDER

96020652

Unit #25 Key #47-180-33
Van Buren & Funkey's 1st Sub Lot 3145 20ft Lot 32 Block 7