* 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.

Local No. 220

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAR 13 1996 Date Issued

Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Emma Bateman

2 SEX: Female

3a TIME OF DEATH: 9:30 A M

3b DATE OF DEATH (Month Day Yr): March 11, 1996

4 *SOCIAL SECURITY NUMBER: 305-20-3108

5a AGE—Last Birthday (Years): 74

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo. Day. Yr): April 10, 1921

7 BIRTHPLACE (City and State or Foreign Country): Augusta, Kenees Arkansas

8a WAS DECEDENT A US VETERAN? No

8b YEAR LAST SERVED IN US ARMED FORCES? ----

8e 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): St. Margaret Hospital

9c CITY, TOWN OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): James Bateman

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker

12b KIND OF BUSINESS/INDUSTRY:

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Hammond

13d STREET AND NUMBER: 7404 Beech Street

13e ZIP CODE: 46324

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): 10th Grade; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): John Lovelace

19 MOTHER'S NAME (First, Middle, Maiden Surname): Lena Not Available

INFORMANT

20a INFORMANT'S NAME (Type/Print): James Bateman

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7404 Beech St. Hammond, Indiana 46324

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 14, 1996 Oak Hill Cemetery

21c LOCATION—City or Town, State: Gary, Indiana

22a EMBALMER'S NAME: Tracy Cheri Williams

22b EMBALMER'S LICENSE NO: FD08600238

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams

24b LICENSE NUMBER (of Licensee): FD08600238

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home FD183001 4859 Alexander Ave. East Chicago, IN

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cerebral Hemorrhage

Conditions if any which gave rise to the immediate cause stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: 96 HR

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I:

27 WAS DECEDENT PREGNANT WITHIN 90 DAYS OF DEATH? (Yes or no): no

28 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):
☒ 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: Ronald Feldner MD

29c MEDICAL LICENSE NO: 018173

29d DATE SIGNED (Month, Day, Year): 3/12/96

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 7905 Columbus Ave Munster IN 46321

31 HEALTH OFFICER'S SIGNATURE: Dr. Fernandez M.D.

32 DATE FILED (Month, Day, Year): March 13 1996

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

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.

dr# 157006

dr# 095223909

Amer General, 2414 Interstate Pl, Hmnd, Ind 46324

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