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

Feb 3, 1994 — Date Issued — Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 255

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Dave Williams Sr.
2 SEX	Male
3a TIME OF DEATH	8:40A M
3b DATE OF DEATH (Month Day Yr)	March 17, 1993
4 SOCIAL SECURITY NUMBER	425-50-2621
5a AGE—Last Birthday (Years)	64
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo. Day, Yr)	Oct. 28, 1928
7 BIRTHPLACE (City and State or Foreign Country)	Pickens, Mississipi
8a WAS DECEDENT A U.S. 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)	Saint 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)	Susie Hudson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Minister
12b KIND OF BUSINESS/INDUSTRY	Clergy
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	East Chicago
13d STREET AND NUMBER	3822 Guthrie St.
13e ZIP CODE	46312
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Berry Williams
19 MOTHER'S NAME (First Middle Maiden Surname)	Rose Unknown

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Susie Williams
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	3822 Guthrie St. East Chicago, IN 46312
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	March 22, 1993 Evergreen Memorial Park
21c LOCATION—City or Town, State	Hobart, Indiana
22a EMBALMER'S NAME	Samuel Smith, Jr.
22b EMBALMER'S LICENSE NO	FDE01019692
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Samuel Smith Jr.
24b LICENSE NUMBER (of Licensee)	FDE01019692
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Divinity Memorial Chapel, 3820 Pulaski St. FH03001570, East Chicago, IN 46312

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. Cardeomyopathy
DUE TO (OR AS A CONSEQUENCE OF)
b. Coronary artery disease
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: Renal failure

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
A Kheirbek	01030716	March 3/19/93

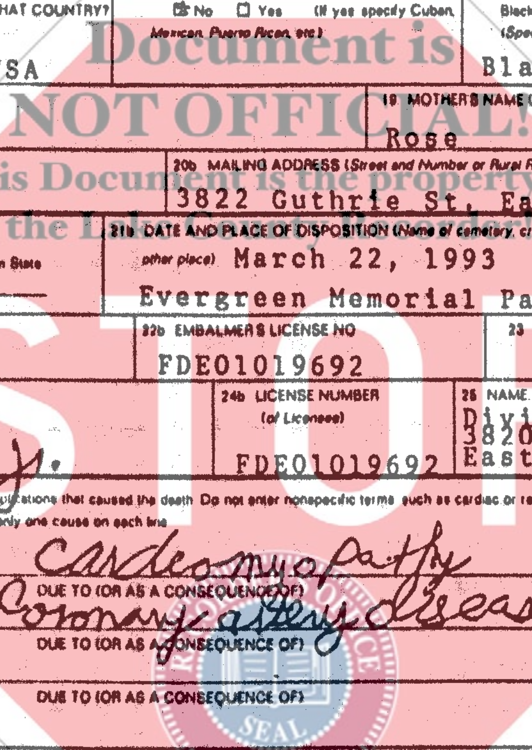
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Ali O. Kheirbek, M.D. 4320 Fir St. Suite 303 East Chicago, IN 46312

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
[signature] M.D.	March 22, 1993

CORONER USE ONLY

Field	Entry
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.	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STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
96 MAY -6 PM 1:03
MARGARET ... RECORDER

Unit #24 Key# 30-339-5 Rebuddiv Lots 6-7 Block 8 East End

FILED
MAY 06 1996
SAM ORLICH AUDITOR LAKE COUNTY
000409

SDH06-004 State Form 10110 (R3/3-92) DEATHCER/PD 1