

47-357-1

STATE OF INDIANA)
COUNTY OF LAKE) ss:

AFFIDAVIT

I, NANCYE (TRUMBO) MITCHELL, being first duly sworn upon my oath depose and state that:

I was married to Allen Alfred Mitchell from January 29, 1954 until his death.

That the incorrect information on his death certificate was not noticed until on or about August, 1996.

That Allen Alfred Mitchell also known as Alfred Allen Mitchell was married and also was self-employed (owned Mitchell's Cleaners).

That this Affidavit is being made to verify that the decedent listed on the death certificate and the name on the deed to 110 Clinton Street, in Gary, Indiana, are one and the same person.

That due to the lapse of time, Affiant is unable to correct any information by way of a "amended death certificate".

FURTHER AFFIANT SAITH NOT.

Nancye T. Mitchell
NANCYE T. MITCHELL

SUBSCRIBED AND SWORN TO BEFORE ME THIS 3rd DAY OF SEPTEMBER, 1996

Bertha Sneed
Bertha Sneed, Notary Public
My Commission Expires: April 24, 1999
RESIDENT: LAKE COUNTY, INDIANA



FILED

SEP 20 1996

SAM ORLICH
AUDITOR LAKE COUNTY

001133

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
SEP 23 AM 10:54
SEP 23 AM 9:21
MARGARET E. CLEVELAND
RECORDER

1180
math 641822926

Frederick Work + Assoc. 640 W 57th AVE GARY 46408

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. ... 0479

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

1. DECEASED—NAME: **ALLEN ALFRED MITCHELL** (FIRST MIDDLE LAST) SEX: **M** DATE OF DEATH (Mon. Day Yr): **JULY 15, 1988**

2. SOCIAL SECURITY NUMBER: **402-07-9395** AGE—Last Birthday (Years): **78** UNDER 1 YEAR: Months Days UNDER 1 DAY: Hours Minutes DATE OF BIRTH (Month, Day, Year): BIRTHPLACE (City and State or Foreign Country): **KENTUCKY**

3. YEAR LAST SERVED IN U.S. ARMED FORCES? PLACE OF DEATH (Check only one box): **HOSPITAL** Inpatient ER/Outpatient DCA OTHER Nursing Home Residence Other (Specify)

4. FACILITY NAME (If not institution, give street and number): **MERCY HOSPITAL** CITY, TOWN OR LOCATION OF DEATH: **GARY** COUNTY OF DEATH: **LAKE**

5. MARITAL STATUS—Married Never Married Widowed: **NEVER** SURVIVING SPOUSE (If wife, give maiden name): **NO** DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): **UNEMPLOYED** KIND OF BUSINESS/INDUSTRY:

6. RESIDENCE—STATE: **INDIANA** COUNTY: **LAKE** CITY, TOWN OR LOCATION: **GARY** STREET AND NUMBER: **353 TYLER STREET**

7. INSIDE CITY LIMITS? (Yes or no): **YES** FARM: **NO** ZIP CODE: WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): **NO** RACE—American Indian, Black, White, etc. (Specify): **BLACK** DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (10-12): College (11-4 or 5 +)

8. FATHER'S NAME (First, Middle, Last): **W. H. HANCOCK** MOTHER'S NAME (First, Middle, Maiden Surname): **LULA H. MITCHELL**

9. INFORMANT'S NAME (Type/Print): **MERCY NURSING HOME** MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): **GARY, IND 46404** Relationship:

10. METHOD OF DISPOSITION: Burial Cremation Removal from State Donation Other (Specify) DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): **JULY 19, 1988—OAKHILL CEMETERY GARY, INDIANA** LOCATION—City or Town, State:

11. SIGNATURE OF FUNERAL DIRECTOR: **Andrew Smith** LICENSE NUMBER: NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: **ANDREW SMITH FUNERAL HOME 934 E. 21ST. AVENUE—000120356**

12. Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: **Sam Orlicz** LICENSE NUMBER: DATE SIGNED (Month, Day, Year):

13. TIME OF DEATH: **M** DATE PRONOUNCED DEAD (Month, Day, Year): WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no):

14. PART I: Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death: **Cerebrovascular accident** (DUE TO (OR AS A CONSEQUENCE OF)) **arteriosclerotic cerebrovascular disease** (DUE TO (OR AS A CONSEQUENCE OF)) **Chronic arteriosclerosis** (DUE TO (OR AS A CONSEQUENCE OF))

15. PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. WAS AN AUTOPSY PERFORMED? (Yes or no): **NO** WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

16. CERTIFIER (Check only one): CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed cause of death) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER CORONER 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) and manner as stated.)

17. SIGNATURE AND TITLE OF CERTIFIER: **K. R. ...** LICENSE NUMBER: **...** DATE SIGNED (Month, Day, Year): **SEP 20 1996**

18. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): **K. R. ...** HEALTH OFFICER'S SIGNATURE: **Sam Orlicz** DATE FILED (Month, Day, Year): **JUL 22 1988**

19. MANNER OF DEATH: Natural Pending Investigation Accident Suicide Could not be Determined Homicide

20. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify): LOCATION (Street and Number or Rural Route Number, City or Town, State): **001134**

