* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 95-0297

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): Annie Bertha WALKER
2. SEX: Female
3a. TIME OF DEATH: 7:02AM
3b. DATE OF DEATH (Month Day Yr): April 14, 1995
4. SOCIAL SECURITY NUMBER: 321-22-6906
5a. AGE - Last Birthday (Years): 82
5b. UNDER 1 YEAR (Months Days):
5c. UNDER 1 DAY (Hours Minutes):
6. DATE OF BIRTH (Mo Day Yr): Dec 17, 1912
7. BIRTHPLACE (City and State or Foreign Country): Castleberry, AL 36432
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. 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): 4371 Harrison Street
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): John Walker
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS INDUSTRY: Domestic
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 4371 Harrison Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE - American Indian, Black, White, etc. (Specify): Afro-Amer
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Ransom George
19. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Frye

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John Walker
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4371 Harrison Street, Gary, IN 46408
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Apr 19, 1995 Mt. Vernon Cemetery
21c. LOCATION - City or Town State: Lamonte, IL
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Sherman D. Banks
24b. LICENSE NUMBER (of Licensee): FDO1011822
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell & Warner 4209 Grant Street, Gary, IN 46408

CAUSE OF DEATH

26. PART I. Enter the disease injuries or complications that caused the death. Do not enter nonspecific terms such as cardiac, respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. CARCINOMA OF BREAST WITH METASTASIS
DUE TO (OR AS A CONSEQUENCE OF):
b.
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 directly related in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28. WAS AN AUTOPSY PERFORMED? (Yes or no): No
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: Bharat Barai
29c. MEDICAL LICENSE NO: 30107
29d. DATE SIGNED (Month Day Year): 4/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Dr. Bharat H. Barai, 125 East 89th Avenue, One Tower Place, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month Day Year): APR 19 1995

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): 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.: No

001600

43-25-3-2

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

900 BS

ATTESTED BY:

HEALTH COMMISSIONER
CITY OF GARY, IND.
APR 19 1995