10cc

Local No. 93-0211   11

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Anthony Lapree Hood
2 SEX	Male
3a TIME OF DEATH	4:12 AM
3b DATE OF DEATH (Month Day Yr)	March 19, 1993
4 SOCIAL SECURITY NUMBER	316-78-4649
5a AGE—Last Birthday (Years)	25
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	March 24, 1967
7 BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
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 ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number)	Methodist Hospital Norhtlake
9c CITY, TOWN OR LOCATION OF DEATH	Gary
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS	Never Married
11 SURVIVING SPOUSE (If wife give maiden name)	N/A
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Coach
12b KIND OF BUSINESS/INDUSTRY	School System
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Gary
13d STREET AND NUMBER	2211 West 8th Avenue
13e ZIP CODE	46404
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? (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+): 5 Years

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Jeremiah Hood Sr.
19 MOTHER'S NAME (First Middle Maiden Surname)	Mabel Williams

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Mabel Hood
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2211 W. 8th Avenue Gary, Indiana 46404
20c Relationship	Mother

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	March 24, 1993 Oak Hill Cemetery
21c LOCATION (City or Town, State)	Gary, Indiana
22a EMBALMER'S NAME	Roosevelt Allen Sr.
22b EMBALMER'S LICENSE NO.	#01051696
23 WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	08700646
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Guy & Allen Funeral Directors, Inc 2959 W. 11th Avenue Gary, Indiana 4640[illegible] 8300770

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Laceration of the right carotid artery	Unknown
DUE TO (OR AS A CONSEQUENCE OF) b.	Due to gunshot wound	
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	Entry
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	No
28a WAS AN AUTOPSY PERFORMED? (Yes or no)	Yes
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	Yes

CERTIFIER

29a CERTIFIER (Check only one) — Chief Investigator

- ☐ 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	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	William C. Huber [signature]
29c MEDICAL LICENSE NO.	N/A
29d DATE SIGNED (Month Day Year)	March 25, 1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	William C. Huber, Chief Investigator, 2293 North Main Street, Crown Point, IN 46307

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature]
32 DATE FILED (Month Day Year)	MAR. 29 1993

CORONER USE ONLY

Field	Entry
33 MANNER OF DEATH	☐ Natural ☐ Accident ☐ Suicide ☒ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month Day Year)	Mar 19,1993
34b TIME OF INJURY	Unknown
34c INJURY AT WORK? (Yes or no)	No
34d DESCRIBE HOW INJURY OCCURRED	Gunshot wound
34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	In Automobile/Street
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)	19th and Pierce Street Gary, Indiana
34g DATE PRONOUNCED DEAD (Month Day Year)	March 19, 1993
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.	No

001645

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

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