ocal No. 91-0767

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

N4 #46-25-9

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Martin Scott
2. SEX: Male
3a. TIME OF DEATH: 10:30P
3b. DATE OF DEATH (Month, Day, Yr): October 11, 1991
4. SOCIAL SECURITY NUMBER: 317-09-7363
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): JAN 12, 1913
7. BIRTHPLACE (City and State or Foreign Country): Monroe, Louisiana
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): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Northlake
9c. CITY, TOWN OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS: Married
11. SURVIVING SPOUSE: Helen L. Cochran
12a. DECEDENT'S USUAL OCCUPATION: Steel Worker
12b. KIND OF BUSINESS/INDUSTRY: USX Big Mill
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 2279 Connecticutt St.
13e. ZIP CODE: 46407
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 Am
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): George Scott
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lue Ida Unavailable

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Helen L. Scott
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2279 Connecticutt St., Gary, In. 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION: Oct 15, 1991 Oakhill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
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: [signature]
24b. LICENSE NUMBER (of Licensee): FD01042607
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell Warner & Son 4209 Grant St., Gary, In. 46408

CAUSE OF DEATH

26. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Congestive Cardiac failure
DUE TO (OR AS A CONSEQUENCE OF):
b. arteriosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Generalized arteriosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Approximate Interval Between Onset and Death

PART II. Other significant conditions: Conditions contributing to death but not resulting in the underlying cause given in Part I: Multiple cerebral infarcts, geriatrics; Urinary Tract Infection

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. 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: [signature]
29c. MEDICAL LICENSE NO: W25043
29d. DATE SIGNED (Month, Day, Year): 10/14/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Krishnan T. Potti, 8300 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Rebera K. Foster, M.D., MPH/at
32. DATE FILED (Month, Day, Year): OCT. 1 5 1991

CORONER USE ONLY

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.

FILED
OCT 07 1996
SAM ORLICH
AUDITOR LAKE COUNTY

000453

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 OCT -7 AM 10
MARGARET [illegible]
RECORDER

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