Local No. 89 0204

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. Cleophas Baker 1633 Maryland St Gary 46407

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: FIRST ARDENIA MIDDLE LAST BAKER
2 SEX: FEMALE
3 DATE OF DEATH (Mo. Day, Yr.): MARCH 31-1989
4 SOCIAL SECURITY NUMBER: 316-22-8991
5a AGE—Last Birthday (Years): 76
5b UNDER 1 YEAR: Months Days
5c UNDER 1 DAY: Hours Minutes
6 DATE OF BIRTH (Month, Day, Year): SEPT 22, 1915
7 BIRTHPLACE (City and State or Foreign Country): MISSISSIPPI
8 YEAR LAST SERVED IN U.S. ARMED FORCES? 19 45
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): ST. MARY MEDICAL CENTER
9c CITY, TOWN OR LOCATION OF DEATH: GARY
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name): ANDREW BAKER
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): BEAUTICIAN
12b KIND OF BUSINESS/INDUSTRY: COSMOTOLOGIST
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: GARY
13d STREET AND NUMBER: 1614 DELAWARE ST
13e INSIDE CITY LIMITS? (Yes or no): YES
13f FARM: NO
13g ZIP CODE: 46407
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☑ No ☐ Yes Specify
15 RACE—American Indian, Black, White, Asian (Specify): AFRO-AMERICAN
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 U; College (1-4 or 5 +)

PARENTS

17 FATHER'S NAME (First, Middle, Last): HENRY McMILLION
18 MOTHER'S NAME (First, Middle, Maiden Surname): MARY EPPS

INFORMANT

19a INFORMANT'S NAME (Type/Print): ANDREW JAMES BAKER
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1614 DELAWARE GARY, IND 46407
19c Relationship: HUSBAND

DISPOSITION

20a METHOD OF DISPOSITION: ☑ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): APRIL 6-1989 EVERGREEN CEMETERY
20c LOCATION—City or Town, State: HOBART INDIANA

PRONOUNCING PHYSICIAN ONLY

21a SIGNATURE OF FUNERAL DIRECTOR: Leon Coleman Jr.
21b LICENSE NUMBER (Embalmer): 104-5230
22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: COLEMAN FUNERAL HOME P.O.B. 1534 Gary, Ind 46402 #43

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b LICENSE NUMBER
23c DATE SIGNED (Month, Day, Year)

24 TIME OF DEATH: 9:50 A.M
25 DATE PRONOUNCED DEAD (Month, Day, Year): MARCH 31 St 1989
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): YES

SEE INSTRUCTIONS

27 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. Carcinoma of the lung
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

Approximate Interval Between Onset and Death: 6 mos.

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a WAS AN AUTOPSY PERFORMED? (Yes or no)
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

SEE INSTRUCTIONS

29a CERTIFIER (Check only one)

☑ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death) To the best of my knowledge, death occurred at the time, date, and place 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.

29b SIGNATURE AND TITLE OF CERTIFIER: Herschel Bornstein MD
29c LICENSE NUMBER: 16469
29d DATE SIGNED (Month, Day, Year): 4/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Herschel Bornstein MD 3290 Grant St Gary IN 46408

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): APR. 3 1989

CORONER OR MEDICAL EXAMINER 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)

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD 1

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SAM ORLICH AUDITOR LAKE COUNTY
STATE OF INDIANA LAKE COUNTY I HEREBY CERTIFY THAT THE WITHIN INSTRUMENT WAS FILED AND RECORDED