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

CERTIFICATE OF DEATH

Local No. 94-0713 State No. 49055LD ①

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-9

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Fredric L. McKinney Sr.
2 SEX: Male
3a TIME OF DEATH: 7:36 pm
3b DATE OF DEATH (Month, Day, Yr.): October 9,1994
4 SOCIAL SECURITY NUMBER: 415-14-5446
5a AGE—Last Birthday (Years): 68
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr.): March 24,1926
7 BIRTHPLACE (City and State or Foreign Country): Marked Tree,Arkansas
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): 4120 West 15th Avenue
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): Evelyn Hunter
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CPA
12b KIND OF BUSINESS/INDUSTRY: Self-Employed
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 4120 West 15th Avenue
13e ZIP CODE: 46404
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 13 College (1-4 or 5+): 5086

PARENTS

15 FATHER'S NAME (First, Middle, Last): Unknown
16 MOTHER'S NAME (First, Middle, Maiden, Surname): Susie B. Fields

INFORMANT

20a INFORMANT'S NAME (Type/Print): Evelyn McKinney
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4120 West 15th Avenue Gary, Indiana 46404
20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 13,1994 Oak Hill Cemetery
21c LOCATION—City or Town, State: Gary,Indiana
22a EMBALMER'S NAME: Patrician Owens
22b EMBALMER'S LICENSE NO: 08700298
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Rosemary Ellis
24b LICENSE NUMBER (of Licensee): 01051701
24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. Gary,Indiana 46404

CAUSE OF DEATH

25 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter 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. Respiratory Failure — Approximate interval: Onset to death: 4 Months
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: b. Metastatic Carcinoma to lungs due to (or as a consequence of) — 12 Months
c. Metastatic Transitional Cell Carcinoma of Bladder due to (or as a consequence of) — 12 months
d.

PART II. Other significant conditions - Conditions contributing to death but not previously mentioned: 26 WAS DECEDENT PREGNANT IN LAST YEAR? No; 27 WAS AN AUTOPSY PERFORMED? (Yes or no) no; 28 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: Barbara L Fuller M.D.
29c MEDICAL LICENSE NO: 01034701
29d DATE SIGNED (Month, Day, Year): 10/27/94
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (Type/Print): Dr. Barbara Fuller 761 45th Street Munster,Indiana 46321 Suite 101

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:
32 DATE FILED (Month, Day, Year): OCT 28 '94

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Could Not Be Determined ☐ Suicide ☐ Homicide
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. 000249

SDH08-004 State Form 10110 (R4/3-93) Deathcer/PD 1

LTS 22,23 & 24, 05, GARY Heights
Key AS-43.157.22 & 24
GARY 1620/13