

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 97-8047

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 10-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Willie Moore		2 SEX Male	3a TIME OF DEATH 3:30 P M	3b DATE OF DEATH (Month Day Yr) January 16, 1997	
4 SOCIAL SECURITY NUMBER 312-05-3250	5a AGE—Last Birthday (Year) 87	5b UNDER 1 YEAR Months Days Months: Days:	5c UNDER 1 DAY Hours Minutes Hours: Minutes:	6 DATE OF BIRTH (Mo Day Yr) February 21, 1909	
7 BIRTHPLACE (City and State or Foreign Country) Georgia	8a WAS DECEDENT A US VETERAN? No				
8b YEAR LAST SERVED IN US ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other (Specify): At Residence			
9a FACILITY NAME (If not institution give street and number) 2585 Jefferson Street		9b CITY TOWN OR LOCATION OF DEATH Gary	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Etta V. Cox	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Laborer		12b KIND OF BUSINESS/INDUSTRY USX Steel Corp.	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 2585 Jefferson Street		
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) Black	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 3rd		18 DECEASED'S FATHER'S NAME (First Middle Last) (UNKNOWN)			
19 DECEASED'S MOTHER'S NAME (First Middle Maiden Surname) (UNKNOWN)		20a INFORMANT'S NAME (Type Print) Etta V. Moore			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2585 Jefferson Street, Gary, Indiana 46407		20c Relationship to Decedent Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) January 22, 1997 Fern Oak Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Roosevelt Allen Sr.		22b EMBALMER'S LICENSE NO. #01051696	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) #08700298	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404		
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF)			
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b. Coronary heart failure DUE TO (OR AS A CONSEQUENCE OF)			
		c. Diabetes DUE TO (OR AS A CONSEQUENCE OF)			
		d.			
PART II: Other significant conditions: Conditions contributing to death but not previously listed in Part I.					
27a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.		27b DECEDENT'S AGE AT DEATH (Type Print) 87		27c DECEDENT'S SEX Male	
28 SIGNATURE AND TITLE OF CERTIFIER 		28a MEDICAL LICENSE NO. 01023563	28b DATE SIGNED (Month Day Year) 1/28/97		
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print) Dr. Raffy Hovanesyan 1805 Broadway Merrillville, Indiana 46410					
30 HEALTH OFFICER'S SIGNATURE 				31 DATE FILED (Month Day Year) JAN 29 1997	
32 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		33a DATE OF INJURY (Month Day Year)	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)	33d DESCRIBE HOW INJURY OCCURRED
		34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34b LOCATION (Street and Number or Rural Route Number, City or Town, State)	
35a DATE PRONOUNCED DEAD (Month Day Year)		35b MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. UUUJ25			

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Robert M. H. CERTIFIED BY.

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE JAN 29 1997