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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0094 State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-16-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Percy B. Hunt Sr.
2 SEX: Male
3a TIME OF DEATH: 2:02 P.M.
3b DATE OF DEATH (Month Day Yr): February 3, 1997
4 SOCIAL SECURITY NUMBER: 421-01-7734
5a AGE—Last Birthday (Years): 75
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo. Day Yr): April 16, 1921
7 BIRTHPLACE (City and State or Foreign Country): Edgewater, Alabama
8a WAS DECEDENT A U.S. VETERAN? Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
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): Methodist Hospital Northlake Campus
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): Ora Lee Lawson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Second Helper (Retired)
12b KIND OF BUSINESS/INDUSTRY: LTV Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1152 Bigger Street
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? ☒ 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) / College (1-4 or 5+): 12th Grade

PARENTS

18 FATHER'S NAME (First Middle Last): Charlie W. Hunt
19 MOTHER'S NAME (First Middle Maiden Surname): Hopie Thornton

INFORMANT

20a INFORMANT'S NAME (Type/Print): Ora Lee Hunt
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1152 Bigger St. Gary, Indiana 46404
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): February 8, 1997 Oak Hill Cemetery
21c LOCATION—City or Town: Gary, Indiana
22a EMBALMER'S NAME: Tracy Cheri Williams
22b EMBALMER'S LICENSE NO.: FT08600238
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b LICENSE NUMBER (of Licensee): FD08600238
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Hinton-Williams Funeral Home FH83001520, 4859 Alexander Avenue, East Chicago, Indiana 46312

97008885

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Old Cerebrovascular Accident
DUE TO (OR AS A CONSEQUENCE OF)
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF)
d. Arteriosclerosis

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.

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a WAS AN AUTOPSY PERFORMED? (Yes or no):
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): -----

STATE OF INDIANA, LAKE COUNTY, FILED FOR RECORD
97 FEB 11 AM 10: 35
MORRIS W. CARTER RECORDER

FILED FEB 11 1997

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.

SAM ORLICH
AUDITOR LAKE COUNTY

29b SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c MEDICAL LICENSE NO.: 01023553
29d DATE SIGNED (Month Day Year): 2/4/97

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D. MPH
32 DATE (Month Day Year): FEB 07 1997

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

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CS

000467

#43-163-16

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1