2CC

*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

Kayett 46-82-25

Local No. 97-0253 CERTIFICATE OF DEATH State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED--NAME (First, Middle, Last): Magnolia Dickens
2. SEX: Female
3a. TIME OF DEATH: 3:05p.m. M
3b. DATE OF DEATH (Month, Day, Yr.): April 06, 1997
4. *SOCIAL SECURITY NUMBER: 303-50-5196
5a. AGE--Last Birthday (Years): 64.
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): February 14, 1933
7. BIRTHPLACE (City and State or Foreign Country): Sallis, Mississippi
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
8c. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9a. FACILITY NAME (If not institution, give street and number): 645 Hovey 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): Charles J. Dickens
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE--STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 645 Hovey Street
13e. ZIP CODE: 46406
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): African-Americ
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): James Roundtree
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie Carter

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Charles J. Dickens
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 645 Hovey Street Gary, IN 46406
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): April 11, 1997 Evergreen Memorial Park
21c. LOCATION--City or Town, State: Hobart, IN
22a. EMBALMER'S NAME: Sherman Banks III
22b. EMBALMER'S LICENSE NO.: FDO 1016254
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Sherman Banks III
24b. LICENSE NUMBER (of Licensee): FDO 1016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home FH 19600034 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 nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
d.

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): No
28b. 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: Ernest Simmons
29c. MEDICAL LICENSE NO.: 18811
29d. DATE SIGNED (Month, Day, Year): 4/11/97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. E.C. Mirich 9001 Broadway 769-3550
31. HEALTH OFFICER'S SIGNATURE: E.C. Mirich MD MPH
32. DATE FILED (Month, Day, Year): APR 14 1997

FILED
APR 17 PM 10:50
SAM ORLICH AUDITOR LAKE COUNTY, IN
RECORDED

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: APR 1 / 1997
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.

SAM ORLICH AUDITOR LAKE COUNTY

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SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1