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ATTENTION ESTATE: Disclosure of the information 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. 95-0027

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Gilbert Dillahunty		2 SEX Male	3a TIME OF DEATH 8:50 A	3b DATE OF DEATH (Month Day Year) January 10, 1995	
4 SOCIAL SECURITY NUMBER 429-32-9142	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) July 23, 1926	
7 BIRTHPLACE (City and State or Foreign Country) Horatio, 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 any and see instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution give street and number) 1760 Fillmore Street		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) Mae C. Sampson	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Expenditer	12b KIND OF BUSINESS/INDUSTRY U S X Steel Corp.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 1760 Fillmore Street		
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S X	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12th		18 FATHER'S NAME (First Middle Last) Bill Hunt			
19 MOTHER'S NAME (First Middle Maiden Surname) Octavia Johnson		20a INFORMANT'S NAME (Type/Print) Mae C. Dillahunty			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1760 Fillmore Street Gary, Indiana 46407		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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 14, 1995 Evergreen Cemetery		21c LOCATION—Copen-Town, State Hobart, 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 <i>Talrose Bradford</i>		24b LICENSE NUMBER (of Licensee) 08700646	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 W. 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 recurring in death) Cerebral vascular accident					
DUE TO (OR AS A CONSEQUENCE OF) Hypertension					
DUE TO (OR AS A CONSEQUENCE OF) ...					
DUE TO (OR AS A CONSEQUENCE OF) ...					
PART II: Other significant conditions - Conditions contributing to death but not primary cause (see Part I)					
27 WAS DECEDENT PREGNANT OR IN LABOUR 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)	
29a CERTIFIER (Check any 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, 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 jurisdiction, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.		29b SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Barton</i>		29c MEDICAL LICENSE NO. 17667	
29d DATE SIGNED (Month Day Year) 1-14-95		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 261 (Type/Print) Dr. Barton 6101 Miller Avenue Gary, Indiana 46403			
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month Day Year) JAN 19 1995		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34i 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.			

Document is NOT OFFICIAL

DECEDENT

INFORMANTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

#45-365-15

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 APR 21 PM 2:00
MORRIS V. CARTER
RECORDER

001155

DJ
CS 9:00