93-0986

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

al No. .... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Surfnee Stokes Allen
2 SEX: Female
3a TIME OF DEATH: 6:19A M
3b DATE OF DEATH (Month, Day, Yr): December 29, 1993
4 SOCIAL SECURITY NUMBER: 308-28-9180
5a AGE—Last Birthday (Years): 63
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr): NOv. 7, 1930
7 BIRTHPLACE (City and State or Foreign Country): Sledge, Miss.
8a WAS DECEDENT A U S VETERAN? no
8b YEAR LAST SERVED IN US ARMED FORCES? none
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): Northwest Family Hospital
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): John H. Allen
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): LPN
12b KIND OF BUSINESS/INDUSTRY: Lincolnshire Nursing Home
13a RESIDENCE—STATE: In.
13b COUNTY: Lake
13c CITY TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1251 Dakota Street
13e ZIP CODE: 46402
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): 12th Grade; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Lemuel Timothy Terry
19 MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Rose Qualls

INFORMANT

20a INFORMANT'S NAME (Type/Print): Audri Collins
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1041 Ivanhoe Ct. Gary, In. 46404
20c Relationship: Daughter

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): January 4, 1994 Evergreen Memorial Park
21c LOCATION—City or Town, State: HObart, In.
22a EMBALMER'S NAME: Rev. Diane E. Weems
22b EMBALMER'S LICENSE NO: FDE 0-100-151-0
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Rev. Diane E. Weems
24b LICENSE NUMBER (of Licensee): FDE 0-100-151-0
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Andrew Smith Funeral Home, Inc. 934 E. 21st Ave. Gary, In. 46407 83002550

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. Diabetes mellitus — Approximate Interval Between Onset and Death: Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF)
c. DUE TO (OR AS A CONSEQUENCE OF)
d. DUE TO (OR AS A CONSEQUENCE OF)

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
Deputy ☒ 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: [signature]
29c MEDICAL LICENSE NO: N/A
29d DATE SIGNED (Month, Day, Year): December 30, 1993
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Paul R. Castro, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month, Day, Year): DEC 30 1993

CORONER USE ONLY

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): 001454 CK 3444 9.00
34g DATE PRONOUNCED DEAD (Month, Day, Year): December 29, 1993
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc

FILED APR 25 1997 SAM ORLICH AUDITOR LAKE COUNTY

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD APR 25 PM 1:20 WILLIAM ... CARTER RECORDER

97026...