

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  
 LAKE COUNTY, INDIANA  
 FILED FOR RECORD

Local No. 96-0498

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Willie Deerell Black		2 SEX (M or F) Male	3 TIME OF DEATH 2:35 PM	4 DATE OF DEATH (Month Day Year) August 1, 1996	
4 SOCIAL SECURITY NUMBER 410-18-9382	5a AGE—Last Birthday (Years) 74	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) September 2, 1921	
7 BIRTHPLACE (City and State or Foreign Country) Tennessee	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) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) 716 Pennsylvania 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) Loris Burr	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during past 12 months) Steel Producer		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 716 Pennsylvania Street		
13e ZIP CODE 46402	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S A	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) Elementary/Secondary (0-12) 8th College (1-4 or 5+) _____			
18 FATHER'S NAME (First Middle Last) James Black		19 MOTHER'S NAME (First Middle Maiden Surname) Linnie Trotter			
20a INFORMANT'S NAME (Type/Print) Lois Black		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Pennsylvania Street, Gary, Indiana 46402		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) August 7, 1996 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, Indiana	
22a EMBALMER'S NAME Patricia Owens		22b EMBALMER'S LICENSE NO. #08700298	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Broadbent</i>		24b LICENSE NUMBER (of Licensee) #08700646	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 disease, 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) Metastatic Carcinoma of the leg. DUE TO (OR AS A CONSEQUENCE OF)					
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last 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) -----		
29a 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					
29b SIGNATURE AND TITLE OF CERTIFIER <i>Lonnie Amico</i>			29c MEDICAL LICENSE NO. 01030325	29d DATE SIGNED (Month, Day, Year) 8/9/96	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr Lonnie Amico 6521 East 86th Avenue Merrillville, Indiana 46410					
31 HEALTH OFFICER'S SIGNATURE <i>Michael W. Bauer</i>			32 DATE FILED (Month, Day, Year) AUG 14 1996		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Unit # 25  
 Key # 44-38-35  
 Gary hand Lois 1st Sub  
 lots 34 & 35 Block 38

**FILED**

SAMORLICH  
 AUDITOR LAKE COUNTY