

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 97-0150

CERTIFICATE OF DEATH

State No.

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

Key# 46-535-11

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

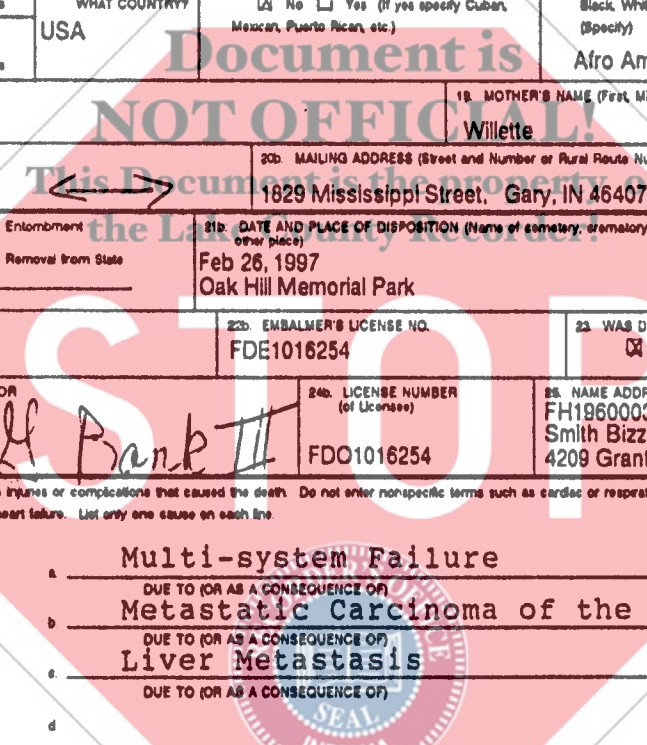
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) Lizette Clark		2. SEX Female	3a. TIME OF DEATH 12:00AM	3b. DATE OF DEATH (Month Day Yr) February 19, 1997
4. SOCIAL SECURITY NUMBER 311-32-0864	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) Nov 28, 1932
7. BIRTHPLACE (City and State or Foreign Country) Buffalo, MS	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a. FACILITY NAME (If not institution, give street and number) Methodist Northlake	9b. CITY TOWN OR LOCATION OF DEATH Gary	9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Divorced	11. SURVIVING SPOUSE (If wife, give maiden name) NONE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Secretary	12b. KIND OF BUSINESS INDUSTRY Clerical	
13a. RESIDENCE - STATE IN	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Gary	13d. STREET AND NUMBER 1829 Mississippi Street	
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) Afro Amer
17. DECEDENT'S EDUCATION (Specify highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 6+) 9 12 5 7 2 1	18. FATHER'S NAME (First, Middle, Last) Steve Walton		19. MOTHER'S NAME (First, Middle, Maiden Surname) Willette	
20a. INFORMANT'S NAME (Type/Print) Felecia Clark	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1829 Mississippi Street, Gary, IN 46407		20c. Relationship Daughter	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Feb 26, 1997 Oak Hill Memorial Park		21c. LOCATION - City or Town State Gary, IN
22a. EMBALMER'S NAME Sherman G. Banks	22b. EMBALMER'S LICENSE NO. FDE1016254	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR Sherman G. Banks III	24b. LICENSE NUMBER (of Licensee) FDO1016254	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH19600034 Smith Bizzell & Warner 4209 Grant Street, Gary, IN 46408		
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions if any which gave rise to the immediate cause stating the underlying cause last		a. Multi-system Failure DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death to week
		b. Metastatic Carcinoma of the Colon DUE TO (OR AS A CONSEQUENCE OF)		Unknown
		c. Liver Metastasis DUE TO (OR AS A CONSEQUENCE OF)		Unknown
		d.		
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) 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 George T. Clardy		29c. MEDICAL LICENSE NO. 01028821	29d. DATE SIGNED (Month Day Year) March 3, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29c) (Type/print) Dr. George T. Clardy, 650 Grant Street, Gary, IN 46407		31. HEALTH OFFICER'S SIGNATURE Sherman G. Banks III		
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) No	34d. LOCATION (Street and Number or Rural Route Number City or Town State) JUL 04 1997 SAM ORLICH
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) AUDITOR LAKE COUNTY			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, etc. No			



STATE OF INDIANA
FILED
LAK
97 JUN 11 10 57 AM '97
RECORDER

FILED
MAR 03 1997

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