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97-0576

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

FILED

* 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.

Local No.

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) Geraldine Turnage				2 SEX Female		3a TIME OF DEATH 9:30 P.M.		3b DATE OF DEATH (Month Day, Year) August 18, 1997	
4 *SOCIAL SECURITY NUMBER 314-42-9526		5a AGE—Last Birthday (Years) 57		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo. Day, Yr) March 30, 1940	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL		8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES?		8c PLACE OF DEATH (Check one) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Residence AUDITOR LAKE COUNTY			
9a FACILITY NAME (If not institution, give street and number) 3361 West 19th Place				9b CITY, TOWN OR LOCATION OF DEATH Gary		9c COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) Widow		11 SURVIVING SPOUSE (If wife, give maiden name)		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of reporting life. Do not use retired) Homemaker			12b KIND OF BUSINESS/INDUSTRY Own Home		
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Gary		13d STREET AND NUMBER 3361 West 19th Place			
13e ZIP CODE 46404		13f INSIDE CITY LIMITS <input 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) Afro-American		16 RACE—American Indian, Black, White etc (Specify)	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1, 4 or 5 +)		18 FATHER'S NAME (First Middle Last) Charles Miller				19 MOTHER'S NAME (First Middle Maiden Surname) Mildred Bulger			
20a INFORMANT'S NAME (Type/Print) Diane McCollum				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3361 West 19th Place Gary, IN 46404				20c Relationship Daughter	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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 23, 1997 Fern Oak Cemetery				21c LOCATION—City or Town, State Griffith, IN	
22a EMBALMER'S NAME Sherman G. Banks III				22b EMBALMER'S LICENSE NO. FDO 1016254		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Sherman G. Banks III</i>				24b LICENSE NUMBER (of Licensee) FDO 1016254		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner Funeral Home 4209 Grant Street, Gary, IN 46408 FH19600034			
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) a. and strong renal failure on Monday DUE TO (OR AS A CONSEQUENCE OF)									
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 RESULTS AVAILABLE PRIOR TO COMPLETION OF CERTIFICATE OF DEATH? (Yes or no)			
29a CERTIFIER (Check only one) <input 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 checked="" 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>Diane M. Gullum MD</i>		29c MEDICAL LICENSE NO. 01020846		29d DATE SIGNED (Month Day, Year) Aug 22, 1997	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Phillips 1356 S. Lake Park									
31 HEALTH OFFICER'S SIGNATURE <i>Diane M. Gullum MD</i>							32 DATE FILED (Month Day, Year) AUG 25 1997		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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 (or street, factory, office, building, etc.) (Specify)				
					34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 000639				
34g DATE PRONOUNCED DEAD (Month Day, Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. NO					

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

STATE OF INDIANA
LAKE COUNTY
FILED
MORRIS V. CARTER
REC. CLERK
97 OCT 15 10:50
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90/3320025

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OFFICE OF THE
CLERK OF THE BOARD OF HEALTH

 CERTIFIED BY. *RMH*

HEALTH COMMISSIONER
CITY OF GARY, IND.

DATE AUG. 25 1987