

94-0158

INDIANA STATE DEPARTMENT OF HEALTH  
STATE OF INDIANA

CERTIFICATE OF DEATH LAKE COUNTY State No. ....

FILED FOR RECORD

Local No. TX # 25-46-0142-0024

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED—NAME (Print name last, first, middle initial) <b>Katie Melton</b>		AGE—Last birthday (Yearly) <b>77</b>		SEX <b>F</b>		DATE OF BIRTH (Month Day Year) <b>MORE FEB 17 1917</b>		DATE OF DEATH (Month Day Year) <b>February 27, 1994</b>	
SOCIAL SECURITY NUMBER <b>351-24-3268</b>		AGE—Last birthday (Yearly) <b>77</b>		SEX <b>F</b>		DATE OF BIRTH (Month Day Year) <b>MORE FEB 17 1917</b>		BIRTHPLACE (City and State or Foreign Country) <b>Tchula, Mississippi</b>	

DECEDENT

WAS DECEDENT A U.S. VETERAN? <b>No</b>			YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>			PLACE OF DEATH (Check only one box) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Prison <input type="checkbox"/> Other (Specify) <input type="checkbox"/> EA/Outpatient <input type="checkbox"/> OOA		
FACILITY NAME (If not identified, give street and number) <b>Northwest Family Hospital</b>			CITY/TOWN OR LOCATION OF DEATH <b>Gary</b>			COUNTY OF DEATH <b>Lake</b>		
MARRITAL STATUS <b>Widowed</b>		SURVIVING SPOUSE (Print name) <b>NONE</b>		DECEDENT'S USUAL OCCUPATION (Give name or work done during part of working life. Do not use retired) <b>Nurse's Assistant</b>		KIND OF BUSINESS-INDUSTRY <b>Miller Merry Manor</b>		
RESIDENCE—STATE <b>Indiana</b>		COUNTY <b>Lake</b>		CITY/TOWN OR LOCATION <b>Gary</b>		STREET AND NUMBER <b>2494 Delaware Street</b>		
ZIP CODE <b>46407</b>		INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>		WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		RACE—American Indian, Black, White, etc. (Specify) <b>Afro Am</b>
FATHER'S NAME (Print name, last) <b>Jefferson</b>		MOTHER'S NAME (Print name, last) <b>Mary</b>		DECEDENT'S EDUCATION (Specify only highest grade completed) Summary/Secondary (9-12) <b>10</b> College (13 or 14) _____				

HOLD FOR: PARENTS OF THIS TITLE SERVICE CO. INFORMATION

FATHER'S NAME (Print name, last) <b>Jefferson</b>		MOTHER'S NAME (Print name, last) <b>Mary</b>		DECEDENT'S EDUCATION (Specify only highest grade completed) Summary/Secondary (9-12) <b>10</b> College (13 or 14) _____	
INFORMANT'S NAME (Type/Print) <b>Ruth Cooley</b>		MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>505 West 52nd Pl, Merrillville, Ind 46410</b>		RELATIONSHIP <b>Daughter</b>	

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) _____		DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>MAR 5, 1994 Oakhill Cemetery</b>		LOCATION—City or Town State <b>Gary, Indiana</b>	
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EMBALMER'S NAME <b>Sherman G. Banks</b>		EMBALMER'S LICENSE NO. <b>FDE1016254</b>		X		WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
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SIGNATURE OF FUNERAL DIRECTOR <i>Paula L. Starnes</i>		LICENSE NUMBER (If Licensed) <b>FDO9100591</b>		NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>FH88900011 Smith Bizzell Warner &amp; Son 4209 Grant St., Gary, In. 46408</b>	
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CAUSE OF DEATH

PART I. State the disease, injury, or compression 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) <b>Cardio-respiratory arrest / Myocardial Infarction</b>			
DUE TO OR AS A CONSEQUENCE OF <b>fasto - intestinal bleeding / Hypertension</b>			
CONDITIONS, if any, which give rise to the immediate cause, stating the underlying cause first <b>Hypertensive Cardiovascular Disease</b>			
DUE TO OR AS A CONSEQUENCE OF			

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM (Yes or no) <b>No</b>		WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>	
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CERTIFIER

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 condition(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 condition(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 condition(s) and manner as stated.		SIGNATURE AND TITLE OF CERTIFIER <i>Cyrill M. Llaneta</i>		MEDICAL LICENSE NO. <b>30385</b>		DATE SIGNED (Month Day Year) <b>3/3/94</b>	
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HEALTH OFFICER

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 23) (Type/Print) <b>Dr. Cyrill M. Llaneta, 26 East 15th Avenue, Gary, Indiana 46407</b>	
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CORONER USE ONLY

HEALTH OFFICER'S SIGNATURE <i>Cyrill M. Llaneta</i>		DATE FILED <b>MAR 04 1994</b>	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Cause not determined <input type="checkbox"/> Homicide		DATE OF INJURY (Month Day Year) <b>DEC 3 1997</b>	
PLACE OF INJURY (Name of place where injury occurred) <b>SAM ORLICH</b>		LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>AUDITOR LAKE COUNTY</b>	
DATE PRONOUNCED DEAD (Month Day Year)		MOTOR VEHICLE ACCIDENT? (Yes or no)	

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9/2/94