

\* 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 non-disclosure.

5CC +3 Free VETS  
INDIANA STATE DEPARTMENT OF HEALTH

STATE OF INDIANA  
LAKE COUNTY  
CERTIFICATE OF DEATH

Local No. ....

State No. FILED FOR RECORD

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle, Last) Otha Williams Jr.	2 TIME OF DEATH 10:00P M		3 DATE OF DEATH (Month, Day, Yr) October 4, 1997	
4 *SOCIAL SECURITY NUMBER 490-24-9125	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) March 4, 1927
7a WAS DECEDENT A U.S. VETERAN? Yes	7b YEAR LAST SERVED IN U.S. ARMED FORCES? 1955	8a 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 Hospital Northlake		9b CITY, TOWN, OR LOCATION OF DEATH Gary	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Venetia WILLIAMS	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Self-employed	12b KIND OF BUSINESS/INDUSTRY	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 1327 Roosevelt Street	
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) College (1-4 or 5+) 2 Years	18 FATHER'S NAME (First, Middle, Last) Otha Williams Sr.	19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary King		
20a INFORMANT'S NAME (Type/Print) Venetia Williams	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Roosevelt Street Gary, Indiana 46404		20c Relationship Wife	
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) October 8, 1997 Fern Oak Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Rosenwald D. Allen JR	22b EMBALMER'S LICENSE NO #29400047	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie D. Bradley</i>	24b LICENSE NUMBER (of Licensee) #08700646	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Gay & 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. <b>FILED</b> Disseminated Intravascular Coagulation DUE TO (OR AS A CONSEQUENCE OF) Septicemia Septicemia with massive ischemic necrosis of the colon Og 1997	Approximate Interval Between Onset and Death 4 hrs 19 hrs 12 hrs			
PART II. Other contributing conditions: Conditions contributing to death but not previously stated in Part I. SANDBOROUGH LAKESIDE LAKE COUNTY	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>Bayne Spotwood</i>	29c MEDICAL LICENSE NO 01033117	29d DATE SIGNED (Month, Day, Year) 10-21-97	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 636 21st Ave Gary IN 46407	31 HEALTH OFFICER'S SIGNATURE <i>Valerie D. Bradley</i>	32 DATE FILED (Month, Day, Year) OCT. 2 2 1997		
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 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)			
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

Key # 47-121-1  
47-156-28

07 DEC - 9 AM 9:01

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