

INDIANA STATE BOARD OF HEALTH

cal No.

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Milton Everett Leatherwood		2 SEX Male	3a TIME OF DEATH 11:04A	3b DATE OF DEATH (Month Day Yr) January 13, 1992	
4 SOCIAL SECURITY NUMBER 317-16-6829	5a AGE—Last Birthday (Years) 67	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) JUN 16, 1924	
7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	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 checked="" type="checkbox"/> Resident <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence <input type="checkbox"/>				
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 Married	11 SURVIVING SPOUSE (If wife give maiden name) Dolores C. McCaskell	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pressman		12b KIND OF BUSINESS/INDUSTRY Budd	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 712 Harrison Street		
13e ZIP CODE 46402	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 type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify) Afro Am	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5+) 0		18 FATHER'S NAME (First Middle Last) Robert Leatherwood			
19 MOTHER'S NAME (First Middle Maiden Surname) Vasti Phifer		20a INFORMANT'S NAME (Type/Print) Dolores C. Leatherwood			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Harrison Street, Gary, Indiana 46402		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) JAN 16, 1992 Fern Oak Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Sherman G. Banks		22b EMBALMER'S LICENSE NO FDE1016254	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ed W</i>		24b LICENSE NUMBER (of Licensee) FDO1042607	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FH88900011 Smith Bizzell Warner & Son 4209 Grant St., Gary, In. 46408		
26 PART I Enter the diseases, 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) a <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF) b _____ DUE TO (OR AS A CONSEQUENCE OF) c _____ DUE TO (OR AS A CONSEQUENCE OF) 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 <i>David E. Ross M.D.</i>			
29c MEDICAL LICENSE NO 01018989		29d DATE SIGNED (Month Day Year) 1-14-92			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. David E. Ross, 1619 West 5th Avenue, Gary, Indiana 46404					
31 HEALTH OFFICER'S SIGNATURE <i>Robert L. ...</i>				32 DATE FILED (Month Day Year) JAN 15 1992	
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, 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.			

Lot 37, Block 27, Gary Land Company's 1st Plat Book 6, Page 15
 Chicago Title Insurance Company
 Key 44-27-38

FILED

DEC 08 1997

SAM OBLICH
AUDITOR LAKE COUNTY

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