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INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. .... State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC 26 PM 2:10

DECEDENT

1. DECEASED—NAME: First: LAVERNE; Middle: CECIL; Last: CAMPBELL
2. SEX: MALE
3. DATE OF DEATH (Mo., Day, Yr.): June 1, 1989
4. SOCIAL SECURITY NUMBER: 313126963
5a. AGE—Last Birthday (Years): 66
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): 12/14/22
7. BIRTHPLACE (City and State or Foreign Country): GARY, IN
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? 97 998841 1943
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL NORTHLAKE
9c. CITY, TOWN, OR LOCATION OF DEATH: GARY
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MYRTLE L. GATLIN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): POSTAL CARRIER
12b. KIND OF BUSINESS/INDUSTRY: U.S. POSTAL SERVICE
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: GARY
13d. STREET AND NUMBER: 1590 HENDRICKS
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46404
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): BLACK
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 3Years

PARENTS

17. FATHER'S NAME (First, Middle, Last): CECIL LAVERNE CAMPBELL
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE GREENWOOD

INFORMANT

19a. INFORMANT'S NAME (Type/Print): MYRTLE L. CAMPBELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1590 HENDRICKS STREET, GARY, IN 46404
19c. Relationship: WIFE

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 9, 1989 Evergreen Cemetery
20c. LOCATION—City or Town, State: Hobart, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): 87000646
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen, 2959 W. 11th Ave., 83007704

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 4:45 PM
25. DATE PRONOUNCED DEAD (Month, Day, Year): June 1, 1989
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. MASSIVE INTRACEREBRAL HEMMORRHAGE
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

FILED
DEC 26 1997
SAM ORLICH
AUDITOR LAKE COUNTY

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Odies H. Williams III MD
29c. LICENSE NUMBER: 01026836
29d. DATE SIGNED (Month, Day, Year): 6-8-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): ODIES H. WILLIAMS III, M.D. 2200 GRANT STREET GARY, INDIANA 46404

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): JUN 14 1989

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)

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