

\*ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.\*

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. ....

97-0370

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) Faye Sims		2 SEX Female	3a TIME OF DEATH 1:40 aa	3b DATE OF DEATH (Month Day Yr) June 2, 1997	
4 *SOCIAL SECURITY NUMBER 412-54-1004		5a AGE—(Years) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr) July 13, 1936		7 BIRTHPLACE (City and State or Foreign Country) Wynn, Arkansas			
8a WAS DECEDENT A US VETERAN? no	8b YEAR LAST SERVED IN US ARMED FORCES? no	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input 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			
9b FACILITY NAME (If not institution give street and number) 501 West 37th Ave.		9c CITY TOWN OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) married	11 SURVIVING SPOUSE (If wife give maiden name) George Sims	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 501 West 37th Ave.		
13e ZIP CODE 46408	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 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) 12th		17 College (1-4 or 5 + )			
18 FATHER'S NAME (First Middle Last) Joseph Jones Jr.		19 MOTHER'S NAME (First Middle Maiden Surname) Lillian Scruggs			
20a INFORMANT'S NAME (Type, Print) George Sims		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 501 West 37th Ave. Gary, Ind 46408		20c Relationship spouse	
21a METHOD OF DISPOSITION <input 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) June 3, 1997 Evergreen Memorial Park		21c LOCATION—City or Town State Hobart, Indiana	
22a EMBALMER'S NAME Leon Coleran Jr.		22b EMBALMER'S LICENSE NO 4523	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) 104-5231	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Powell-Lewis Funeral Home- 1901 West 37th Ave. Gary, Ind. 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 myocardial infarction					
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 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>[Signature]</i>		29c MEDICAL LICENSE NO H01037803	
29d DATE SIGNED (Month Day Year) 6/2/97		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITM 2674 Type/Print) Daryl Fortson 2717 Kabash Ave. Gary, Indiana			
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month Day Year) JUN 03 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"/> Homicide <input type="checkbox"/> Could not be Determined		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

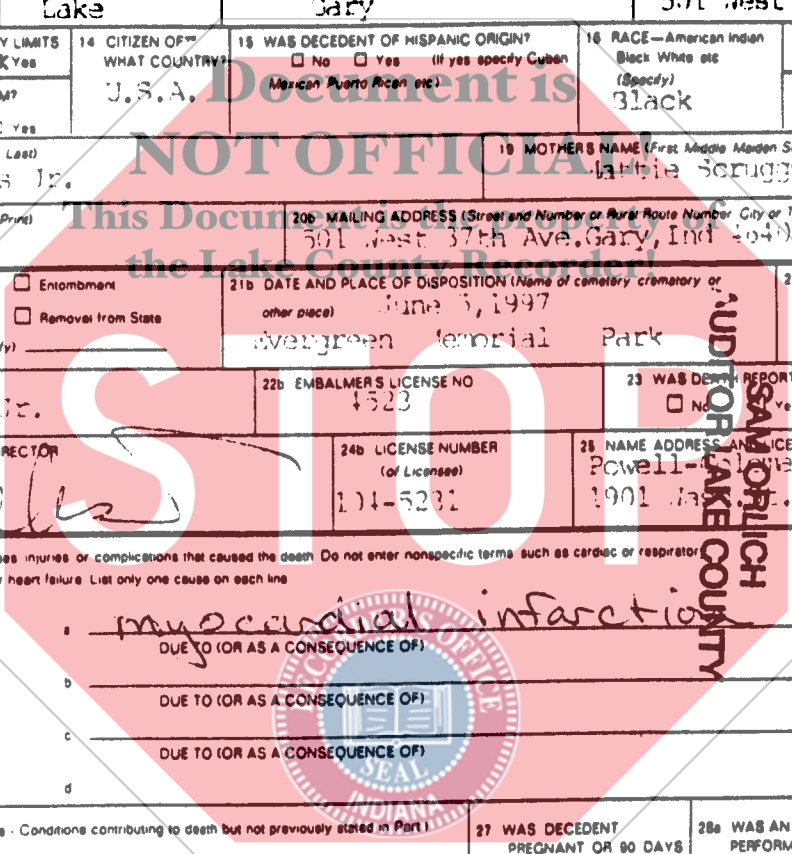
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

# 45-135-1



JUD FOR LAKE COUNTY

APR 27 1997

000426

900 PM CS