

STATE DEPARTMENT OF HEALTH

Key# 47-311-18

Local No. 94-0781

CERTIFICATE OF DEATH

State No.

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) Imagean Grady		2 SEX Male	3a TIME OF DEATH 9:37 am	3b DATE OF DEATH (Month Day Year) November 8, 1994
4 SOCIAL SECURITY NUMBER 347-12-1945	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 11, 1924
7 BIRTHPLACE (City and State or Foreign Country) Mississippi	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a 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	
9b FACILITY NAME (If not institution, give street and number) Northwest Family Hospital		9c CITY TOWN OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Bezell Buchanan	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) chipper	12b KIND OF BUSINESS/INDUSTRY US	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 1544 Garfield Street	
13e ZIP CODE 46404	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 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 +) 12th	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	18 FATHER'S NAME (First Middle Last) George Grady		
19 MOTHER'S NAME (First Middle Maiden Surname) Whitley (Unknown)		20a INFORMANT'S NAME (Type/Print) Bezell Grady		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1544 Garfield Street Gary, Indiana 46404		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 12, 1994 Fern Oak Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Roosevelt Allen Sr.	22b EMBALMER'S LICENSE NO. 01051696	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Roosevelt Allen Sr.</i>	24b LICENSE NUMBER (of Licensee) 08700646	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2959 West 11th Avenue Gary, Indiana 46404 83007704		
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 Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF) b Hypertensive Heart Disease c Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF) d Pelvic Ulcer Disease				
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 NOT FOREMENSES 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 X <i>[Signature]</i>		29c MEDICAL LICENSE NO. 01036654	29d DATE SIGNED (Month Day Year) 11/14/94	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ADOLPHUS A. ANEKWE, M.D. 3195 BROADWAY GARY, INDIANA 46408				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month Day Year) NOV 23 1994
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.		000727		

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SAM ORLICH AUDITOR LAKE COUNTY

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