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

Local No. 94-0843

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Marvin Coley
2 SEX: Male
3a TIME OF DEATH: 7:00A
3b DATE OF DEATH (Month, Day, Yr.): 11-25-94
4 *SOCIAL SECURITY NUMBER: 339-18-8538
5a AGE—Last Birthday (Years): 81
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day Yr.): 2-22-1913
7 BIRTHPLACE (City and State or Foreign Country): Dyersburg, Tenn.
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): West Side Health Care Center
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): Cleolar Blakes
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Boiler Technician
12b KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 2170 Tennessee Street
13e ZIP CODE: 46407
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): 11th Grade; College (1-4 or 5 +):

Held for NTC

PARENTS

18 FATHER'S NAME (First, Middle, Last): Marvin D. Coley Sr.
19 MOTHER'S NAME (First, Middle, Maiden, Surname): Carrie B. Swift

INFORMANT

20a INFORMANT'S NAME (Type/Print): Carrie Broughton
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 176 13 Anthony Country Club Hills,
20c RELATIONSHIP: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 11-30-94 Evergreen MEmorial Park
21c LOCATION—City or Town, State: Hobart, Indiana
22a EMBALMER'S NAME: Rev. Diane E. Weems
22b EMBALMER'S LICENSE NO: FDE 0-100-151-0
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Rev Diane E. Weems
24b LICENSE NUMBER (or Licensee): FDE 0-100-151-0
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Andrew Smith Funeral Home, Inc. 934 E. 21st Ave. Gary, In. 464C 8300255C

CAUSE OF DEATH

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Possible Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Multiple Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
d. Organic Brain Syndrome

Conditions if any which gave rise to the immediate cause stating the underlying cause last

PART II. Other significant conditions. Conditions contributing to death but not directly related to Part I: Bowel Resection with Colostomy

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

CERTIFIER

29a CERTIFIER (Check only one): ☒ CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date and place and due to the cause(s) as stated. ☐ 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. ☐ 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: MD
29c MEDICAL LICENSE NO: 10-29954
29d DATE SIGNED (Month, Day, Yr.): 11.29.94

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: 11-2 1998
32 DATE FILED (Month, Day, Yr.): DEC 01 1998

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: SAM ORLICH TRITOR LAKE COUNTY
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.

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

CK# 1980