* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

4cc

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Key # 42-240-2
45-454-5

Local No. 97-0096 — State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Herman Mitchell
2. SEX: Male
3a. TIME OF DEATH: 8:53 A
3b. DATE OF DEATH (Month, Day, Yr): February 7, 1997
4. *SOCIAL SECURITY NUMBER: 313-18-5061
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): May 17, 1921
7. BIRTHPLACE (City and State or Foreign Country): Virginia
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XXX Residence
9b. FACILITY NAME (If not institution, give street and number): 4006 Washington Street
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): Josephine Patterson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer
12b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel Corp.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 4006 Washington Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: ☐ No XXX Yes
13g. ON A FARM? XXX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? XXX 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; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Sidney Mitchell
19. MOTHER'S NAME (First, Middle, Maiden Surname): Geneva (UNKNOWN)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Josephine Mitchell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4006 Washington Street Gary, Indiana 46408
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 14, 1997 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO.: #01051696
23. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): #08700646
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiorespiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Carotid Artery Stenosis
DUE TO (OR AS A CONSEQUENCE OF):
d. Chronic Obstructive Lung Disease

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

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously related 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)

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: Idah Cannon MD
29c. MEDICAL LICENSE NO.: 01037499
29d. DATE SIGNED (Month, Day, Year): 2/10/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Idah Cannon 1619 West 5th Avenue Gary, Indiana 46402

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] FILED
32. DATE FILED (Month, Day, Year): FEB 19 1997

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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

JUN 16

SAM ORLICH
AUDITOR LAKE COUNTY

FILED FOR RECORD
STATE OF INDIANA
LAKE COUNTY

9.00
cm
cash

001263

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