CAC

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

Local No. 95 0356

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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 TRAYLOR
2. SEX: Male
3a. TIME OF DEATH: 4:45PM
3b. DATE OF DEATH (Month Day Yr): May 9, 1995
4. SOCIAL SECURITY NUMBER: 311-46-4477
5a. AGE - Last Birthday (Years): 50
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): May 5, 1945
7. BIRTHPLACE (City and State or Foreign Country): Como, MS 38619
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: N/A
8c. PLACE OF DEATH (Check only one See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9a. FACILITY NAME (If not institution, give street and number): 4334 East 10th Avenue
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): Dorothy Jean Mathis
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Unemployed
12b. KIND OF BUSINESS/INDUSTRY: None
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 4334 East 10th Avenue
13e. ZIP CODE: 46403
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): Afro Amer
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Ivory Traylor
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rachael Hunt

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Dorothy Jean Traylor
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4334 East 10th Avenue, Gary, IN 46403
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 13, 1995 Evergreen Memorial
21c. LOCATION - City or Town State: Hobart IN
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

STATE OF INDIANA LAKE COUNTY FILE FOR RECORD JUN 17 12:5 RECORDED

24a. SIGNATURE OF FUNERAL DIRECTOR: Edward W
24b. LICENSE NUMBER (of Licensee): FDO1042607
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell & Warner 4209 Grant Street Gary, IN 46408

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. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF)
b. Cardiac arrhythmia
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

Approximate Interval Between Onset and Death

FILED JUN 17 1995

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Hypertension

27. WAS DECEDENT PREGNANT OR 60 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
29c. MEDICAL LICENSE NO: 01035471
29d. DATE SIGNED (Month Day Year): 5-10-95

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Harish Shah, 209 East 86th Court, Merrillville, IN 46410
31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month Day Year): MAY 11 1995

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month Day Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no): 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.: No

001367 9:00 PM

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

Pin#25-41-0027-0021 CK#5167

Return to: The Associates
429 W. 81st St.
Merrillville, IN
4 6410

HEALTH COMMISSIONER
CITY OF GARY, IND.
DATE MAY 11 1995