

INDIANA STATE DEPARTMENT OF HEALTH

6800 Coika's
7870 Broadway Suite A
Merrillville, IN 46410

File No. 93-0697

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

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POSITION

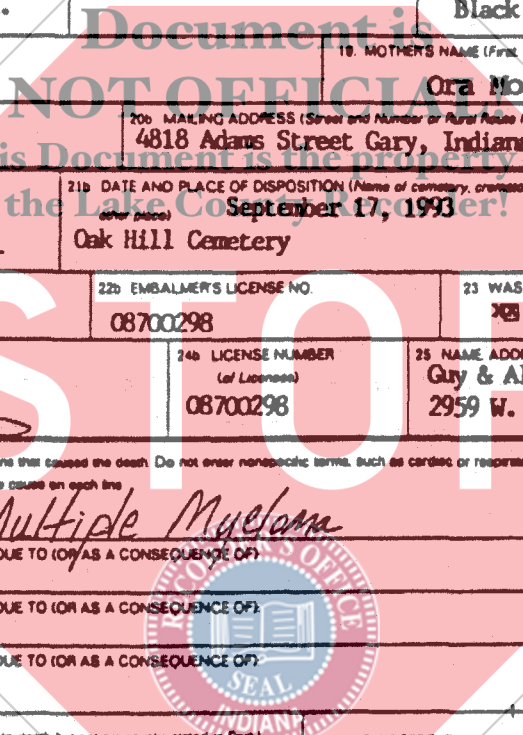
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ONLY

1 DECEASED—NAME (First Middle Last) Lennie B. Puckett		2 SEX Female	3a TIME OF DEATH 12:37 a. m.	3b DATE OF DEATH (Month Day Yr) September 14, 1993	
4 SOCIAL SECURITY NUMBER 350-22-6017	5a AGE—Last Birthday (Years) 67	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (MM Day Yr) January 18, 1926	
7 BIRTHPLACE (City and State or Foreign Country) Lexington, Mississippi	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.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake		9c CITY, TOWN, OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Divorced	11 SURVIVING SPOUSE (If wife, give maiden name) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Caseworker		12b KIND OF BUSINESS/INDUSTRY Calumet Township Trustee	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary		13d STREET AND NUMBER 1982 Whitcomb Street	
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S. A.	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) 1 year College (1-4 or 5+) 1 year		18 FATHER'S NAME (First Middle Last) Jack Grant			
19 MOTHER'S NAME (First Middle, Maiden Surname) Ora Moore		20a INFORMANT'S NAME (Type/Print) Earl Puckett II			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4818 Adams Street Gary, Indiana 46408		20c Relationship Son			
21a METHOD OF DISPOSITION <input checked="" 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) September 17, 1993 Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana	
22a EMBALMER'S NAME Patrician Owens		22b EMBALMER'S LICENSE NO. 08700298		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) 08700298		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 83007704 2959 W. 11th Ave. Gary, IN 46404	
26. PART I Enter the disease, 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) Multiple Myeloma					
DUE TO (OR AS A CONSEQUENCE OF)					
DUE TO (OR AS A CONSEQUENCE OF)					
DUE TO (OR AS A CONSEQUENCE OF)					
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 Barbara L. Fuller, M.D.			
29c. MEDICAL LICENSE NO. 01034701		29d. DATE SIGNED (Month Day, Year) 9/20/93			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) Barbara L. Fuller, M.D. 3229 Broadway Gary, IN 46409					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month Day, Year) SEP. 24 1993	
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.			



FILED
JUN 22 1993
S.A.M. ORLICH
HEALTH DEPARTMENT
LAKE COUNTY, INDIANA

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#6377900/KSA