3cc

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

Local No 2009-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Key # 46.62.9

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): Mattie Jane Esters

2 SEX: Female

3a TIME OF DEATH: 10:07AM

3b DATE OF DEATH (Month Day Yr): May 26, 1996

4 SOCIAL SECURITY NUMBER: 311-48-9154

5a AGE - Last Birthday (Years): 87

5b UNDER 1 YEAR (Months Days):

5c UNDER 1 DAY (Hours Minutes):

6 DATE OF BIRTH (Mo Day Yr): Aug 9, 1908

7 BIRTHPLACE (City and State or Foreign Country): Weir, MS 39772

8a WAS DECEDENT A U S VETERAN?: No

8b YEAR LAST SERVED IN U S ARMED FORCES: N/A

8e PLACE OF DEATH (Check only one See Instructions): [X] HOSPITAL Inpatient [ ] ER/Outpatient [ ] DOA; [ ] OTHER Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution give street and number): Saint Mary Medical Center 98049717

9c CITY TOWN OR LOCATION OF DEATH: Hobart

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Widowed

11 SURVIVING SPOUSE (If wife, give maiden name): NONE

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker

12b KIND OF BUSINESS INDUSTRY: Domestic

13a RESIDENCE - STATE: IN

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 1632 Carolina

13e ZIP CODE: 46407

13f INSIDE CITY LIMITS: [ ] No [X] Yes

13g ON A FARM?: [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY?: USA

16 WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)

18 RACE - American Indian Black, White, etc. (Specify): Afro Amer

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 03; College (1-4 or 5+):

PARENTS

19 FATHER'S NAME (First Middle Last): Buster Christopher

19 MOTHER'S NAME (First, Middle, Maiden Surname): Janie Edwards

INFORMANT

20a INFORMANT'S NAME (Type Print): Ida M Sain

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1044 East 36th Place, Gary, IN 46409

20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 30, 1996 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? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR

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. Cerebra Vascular accident, Bilateral Pneumonia

DUE TO (OR AS A CONSEQUENCE OF)

b. hypertensive pressure, Congestive heart failure

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

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): No

FILED

CERTIFIER

29a CERTIFIER (Check only one):
[X] 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.

JUL 01 1996

29b SIGNATURE AND TITLE OF CERTIFIER

29c MEDICAL LICENSE NO: 33934

29d DATE SIGNED (Month Day Year): 5/28/96

SAM ORLICH
AUDITOR LAKE COUNTY

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr Sanath Kumar, 3156 Willow Creek Road, Portage, IN 46368

31 HEALTH OFFICER'S SIGNATURE: Alexander D. Williams MD

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF DEATH ON FILE IN THIS OFFICE

DATE FILED (Month Day Year): JUL 01 1996

33 MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

34a DATE OF INJURY (Month Day Year): MAY 29 1996

34b TIME OF INJURY: 9:00 CM

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):

Alexander D. Williams MD CG94
LAKE COUNTY HEALTH COMMISSIONER

34g DATE PRONOUNCED DEAD (Month, Day, Year):

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

000168

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

1632 Carolina St. Gar-I IN 46407