L.C.C.

INDIANA STATE BOARD OF HEALTH

Local No. 89 0055

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME FIRST: ESTELLE	MIDDLE	LAST: BROTHERS		2 SEX: FEMALE	3 DATE OF DEATH (Mo. Day. Yr.): JAN 31, 1989	
4 SOCIAL SECURITY NUMBER: 425-30-7755	5a AGE—Last Birthday (Years): 67	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6a DATE OF BIRTH: AUG 8, 1921	7 BIRTHPLACE (City and State or Foreign Country): SHREVESPORT, LA	
8 YEAR LAST SERVED IN U.S. ARMED FORCES?: No	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: ☑ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)				
9b FACILITY NAME (If not institution, give street and number): Methodist Hosp. Northlake	9c CITY, TOWN OR LOCATION OF DEATH: Gary	9d COUNTY OF DEATH: Lake				
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced: Married	11 SURVIVING SPOUSE (If wife give maiden name): Joe Brothers	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ateress	12b KIND OF BUSINESS/INDUSTRY: Self-Employed			
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN, OR LOCATION: Gary	13d STREET AND NUMBER: 1726 Hayes St			
13e INSIDE CITY LIMITS? (Yes or no): Yes	13f FARM: No	13g ZIP CODE: 46404	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify): Black	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):	
17 FATHER'S NAME (First, Middle, Last): HENRY BROWN		18 MOTHER'S NAME (First, Middle, Maiden Surname): MARY BROWN BROWN				
19a INFORMANT'S NAME (Type/Print): Joe Brothers	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1726 Hayes St Gary, Ind	19c Relationship: Husband				
20a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Feb 3, 1989 OAK HILL	20c LOCATION—City or Town, State: GARY, IND				
21a SIGNATURE OF FUNERAL SERVICE REPRESENTATIVE: Paul Anthony Robinson	21b LICENSE NUMBER (of licensee): 1017284	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: ENNOLS & ROBINSON MEMORIAL CHPL 1900 W. 15th Ave Gary, IN 3002495				
Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death	23a To the best of my knowledge, death occurred at the time, date and place stated. Signature and Title: <	23b LICENSE NUMBER	23c DATE SIGNED (Month Day Year)			
24. TIME OF DEATH: 10:16 PM	25 DATE PRONOUNCED DEAD (Month, Day, Year): January 13, 1989	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): No				

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Cardio - Respiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF):
b. ASPIRATION Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):
c. Cerebral Vascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.
d.

Approximate Interval Between Onset and Death:

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:

28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

FILED JUL 14 1998

SAM ORLICH
AUDITOR LAKE COUNTY

29a CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician other than pronouncing physician certifying cause of death when another physician has pronounced death and completed item 23)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 98 JUL 15 PM 3:55 MORRIS RECORDER

29b SIGNATURE AND TITLE OF CERTIFIER: Donald Tucker MD	29c LICENSE NUMBER: 03156	29d DATE SIGNED (Month, Day, Year): Feb 1 1989
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Dr Donald Tucker 1619 W. 5th Ave Gary, Ind		
31 HEALTH OFFICER'S SIGNATURE:		32 DATE FILED (Month, Day, Year): FEB. 2 1989

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

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327-3138

William Jones