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

Local No. 1080-98 9413

TYPE/PRINT IN PERMANENT BLACK INK

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

98 016769

DECEDENT

1 DECEASED—NAME (First Middle Last): James Scott
2 SEX: Male
3a TIME OF DEATH: 7:20p M
3b DATE OF DEATH (Month Day Yr): April 15, 1998
4 SOCIAL SECURITY NUMBER: 403-38-5587
5a AGE—Last Birthday (Years): 66
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo. Day Yr): December 26,1998
7 BIRTHPLACE (City and State or Foreign Country): Kentucky
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: N/A
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Marys Medical Center
9c CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Toni Scott
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steelworker
12b KIND OF BUSINESS/INDUSTRY: Auto
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Miller
13d STREET AND NUMBER: 8960 E 6th Apt 212
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify): White
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First Middle Last): John Scott
19 MOTHER'S NAME (First Middle Maiden Surname): Dova Jennings

INFORMANT

20a INFORMANT'S NAME (Type/Print): Toni Scott
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8960 E 6th Ave Apt 212 Miller IN 46403
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 19, 1998 Northwest Indiana Cremation
21c LOCATION—City or Town, State: Crownpoint
22a EMBALMER'S NAME: Chris Podgorski
22b EMBALMER'S LICENSE NO: FD29300030
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD29300030
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Christopher Funeral Home 1307 Central Ave. Lake StationIN

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF)
b.
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

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): N/A

FILED SEP 22 1998 SAM ORLICH

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: Sharon Hang, MD
29c MEDICAL LICENSE NO: 01035172
29d DATE SIGNED (Month Day Year): 5-3-98
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 8895 Broadway

HEALTH OFFICER

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

I HEREBY CERTIFY THIS TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

MAY 04 1998

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

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.:

001551

9a M

Toni Scott P.O. Box 5411 Lake Station In 46405

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

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