r3 Free VA

INDIANA STATE BOARD OF HEALTH

Local No. 90 0685 — CERTIFICATE OF DEATH — State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
Booker	Jackson	Male	08:00P M	September 26, 1990

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
429-62-2443	70			JUL 30, 1920	Vanndale, Arkansas

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions.)
Yes	1946	X HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital Northlake	Gary	Lake

10 MARITAL STATUS	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Ruthia M. Hare	Foundry Worker	Rockwell Spring & Axle

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	2933 Central Drive

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46407	☐ No ☐ Yes	X ☐ No ☐ Yes	USA	☐ No ☐ Yes	Afro Am	7	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
McKinley Jackson	Anna Redd

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Ruthia M. Jackson	2933 Central Drive, Gary, Indiana 46407	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION (City or Town, State)
X ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	OCT 1, 1990 Evergreen Memorial	Hobart, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Sherman G. Banks	FDE1016254	X ☐ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Edg Wa	FDO1042607	FDU300246 Smith Bizzell & Warner 2295 Washington St. Gary, In. 46407

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)

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

		Approximate Interval Between Onset and Death
a	Metastatic Cancer of Pancreas	9 months
b	DUE TO (OR AS A CONSEQUENCE OF)	
c	DUE TO (OR AS A CONSEQUENCE OF)	
d	DUE TO (OR AS A CONSEQUENCE OF)	

FILED AUG 18 1999 PETER BENJAMIN LAKE COUNTY AUDITOR

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)	28a WAS AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

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

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO.	29d DATE SIGNED (Month, Day, Year)
Barbara A Fuller, M.D.	01034701	9/27/90

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Barbara Fuller, 3229 Broadway, Gary, Indiana 46408

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Rebecca E Foster MD for 9/28/90	SEP 28 1990

CORONER USE ONLY

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 Ooccurred
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				001409

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.

SBH06-004 State Form 10110 (R2/3-90) DEA CERT-RD-1

Town & Country Title 9111 Broadway Ste E Merr 1/14/40