/ Hammond

92-0872 ✓ Cordell Reed / CORDELL REED

Local No. ....

TAX MAIL 1912 Maryland Gary, IND

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

(25) Key 47-320-4

STATE OF INDIANA 47-320-20
State No. LAKE COUNTY ....

FILED FOR RECORD 1993 OCT 1 PM 12:18 — RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Item	Entry
1 DECEASED—NAME (First Middle Last)	EDITH VAL HARRIS 99081075
2 SEX	FEMALE
3a TIME OF DEATH	4:43 PM
3b DATE OF DEATH (Month Day Yr)	NOV 26,1992
4 SOCIAL SECURITY NUMBER	319-18-3864
5a AGE—Last Birthday (Years)	84
5b UNDER 1 YEAR Months Days	
5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr)	8-04-1908
7 BIRTHPLACE (City and State or Foreign Country)	MERRICK,LOUISANA
8a WAS DECEDENT A U.S. VETERAN?	NO
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	NO
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	ST.MARY MEDICAL CENTER
9c CITY, TOWN, OR LOCATION OF DEATH	GARY
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	WIDOWED
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)	HOMEMAKER
12b KIND OF BUSINESS/INDUSTRY	Own Home
13a RESIDENCE—STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN OR LOCATION	GARY
13d STREET AND NUMBER	2237 CHASE ST.
13e ZIP CODE	46404
13f INSIDE CITY LIMITS	☐ No XX Yes
13g ON A FARM?	XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	XX No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	BLACK
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5+)	

PARENTS

Item	Entry
18 FATHER'S NAME (First Middle Last)	THOMAS HARRIS
19 MOTHER'S NAME (First Middle Maiden Surname)	ADDIE HOLLINS

INFORMANT

Item	Entry
20a INFORMANT'S NAME (Type/Print)	CORDELL HARRIS
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1912 MARYLAND ST. GARY,IND 46407
20c Relationship	NEPHEW

DISPOSITION

Item	Entry
21a METHOD OF DISPOSITION	XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	NOV.30-92 OAKHILL CEMETERY
21c LOCATION—City or Town, State	GARY,INDIANA
22a EMBALMER'S NAME	LEON COLEMAN JR.
22b EMBALMER'S LICENSE NO	4523
23 WAS DEATH REPORTED TO CORONER?	XX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Leon Coleman Jr
24b LICENSE NUMBER (of Licensee)	2364
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	POWELL-COLEMAN FUNERAL Home 1901 WASH.ST.GARY,IND 88602434

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)		Approximate Interval Between Onset and Death
a.	CARDIO PULMONARY ARREST	
b. DUE TO (OR AS A CONSEQUENCE OF)	RENAL FAILURE & SEPSIS	
c. DUE TO (OR AS A CONSEQUENCE OF)	GANGRENE OF LEFT LOWER EXTREMITY	
d. DUE TO (OR AS A CONSEQUENCE OF)	COMPLETE ARTERIAL OCCLUSION OF LLE	

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:

Item	Entry
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)	—

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

Item	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Milton Bergall MD
29c MEDICAL LICENSE NO	18128
29d DATE SIGNED (Month Day Year)	12/8/92
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	MILTON BERGALL, M.D. 2318 W. 5th Ave., Gary, IN

HEALTH OFFICER

Item	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature] MD
32 DATE FILED (Month Day Year)	DEC 8 1992

CORONER USE ONLY

Item	Entry
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.	

FILED

OCT 01 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

9.00
E.P.
CS

000062

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1