12 cc

Key No. 8-15-372-10

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2084-99 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): ALFRED CLYDE JONES SR.

2 SEX: Male

3a TIME OF DEATH: 4:05 A.M.

3b DATE OF DEATH (Month Day Yr): September 13, 1999

4 *SOCIAL SECURITY NUMBER: 253-22-1526

5a AGE—Last Birthday (Years): 75

5b UNDER 1 YEAR Months Days: 5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo Day Yr): June 2, 1924

7 BIRTHPLACE (City and State or Foreign Country): Lindale, Georgia

8a WAS DECEDENT A U.S. VETERAN? Yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954

9a PLACE OF DEATH (Check only one See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution give street and number): Methodist Hospital Southlake Campus

9c CITY TOWN OR LOCATION OF DEATH: Merrillville

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Thelma Smith

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

12b KIND OF BUSINESS/INDUSTRY: Heating & Air Conditioning

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Merrillville

13d STREET AND NUMBER: 2917 W. 79th Place

13e ZIP CODE: 46410

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

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

14 CITIZEN OF WHAT COUNTRY? U.S.A.

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

16 RACE—American Indian Black White etc (Specify): White

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

PARENTS

18 FATHER'S NAME (First Middle Last): William Lewis Jones

19 MOTHER'S NAME (First Middle Maiden Surname): Lillis Lee Murphy

INFORMANT

20a INFORMANT'S NAME (Type/Print): Thelma Mae Jones

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2917 W. 79th Place, Merrillville, Indiana 46410

20c Relationship: Wife

DISPOSITION

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

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): September 16, 1999 Calumet Park Cemetery

21c LOCATION—City or Town State: Merrillville, Indiana

22a EMBALMER'S NAME: Ronald J. Mesarch

22b EMBALMER'S LICENSE NO: FD01005912

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Ronald J. Mesarch

24b LICENSE NUMBER (of Licensee): FD01005912

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410

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. Respiratory Failure OCT 14 1999

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

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

DUE TO (OR AS A CONSEQUENCE OF): d.

SEP 15 1999

Approximate Interval Between Onset and Death

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

LAKE COUNTY HEALTH COMMISSIONER

PETER BENJAMIN LAKE COUNTY AUDITOR

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Congestive Heart Failure

27 WAS DECEDENT PREGNANT OR 30 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

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 [ ] [illegible] [ ] 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: Alexander D. Gillespie M.D.

29c MEDICAL LICENSE NO: 01035172

29d DATE SIGNED (Month Day Year): 10-9-15-99

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Sharon Harig, M.D., 8895 Broadway, Merrillville, Indiana 46410

31 HEALTH OFFICER'S SIGNATURE: Alexander D. Gillespie M.D.

32 DATE FILED (Month Day Year): September 15 1999

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

34a DATE OF INJURY (Month Day Year):

34b [illegible] INJURY:

34c [illegible] (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

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

FILED SEP 15 1999 LAKE COUNTY AUDITOR

9.00 OS