* **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.

Local No. 2074-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED—NAME (First, Middle, Last): Alex Ferguson
- 2. SEX: Male
- 3a. TIME OF DEATH: 6:44p M
- 3b. DATE OF DEATH (Month, Day, Yr): September 11,1999
- 4. *SOCIAL SECURITY NUMBER: 321-05-5094A
- 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): April 29,1915
- 7. BIRTHPLACE (City and State or Foreign Country): Kilmarnock, Scotland
- 8a. WAS DECEDENT A U.S. VETERAN?: No
- 8b. YEAR LAST SERVED IN U.S. 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. Anthony Medical Center
- 9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
- 9d. COUNTY OF DEATH: Lake
- 10. MARITAL STATUS (Specify): Married
- 11. SURVIVING SPOUSE (If wife, give maiden name): Lucille
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Plant Superintent
- 12b. KIND OF BUSINESS/INDUSTRY: Pump Co.
- 13a. RESIDENCE—STATE: IN
- 13b. COUNTY: Lake
- 13c. CITY, TOWN, OR LOCATION: Cedar Lake
- 13d. STREET AND NUMBER: 11520 West 133rd Lane
- 13e. ZIP CODE: 46303
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Matthew Ferguson
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Euphemia Beattie

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Lucille Ferguson
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11620 West 133rd Lane, Cedar Lake
- 20c. Relationship: Wife

DISPOSITION

- 21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 15,1999 Cedar Park Cemetery
- 21c. LOCATION—City or Town, State: Calumet Park, IL
- 22a. EMBALMER'S NAME: William E. Burdan
- 22b. EMBALMER'S LICENSE NO.: FD01007697
- 23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: William E. Burdan
- 24b. LICENSE NUMBER (of Licensee): FD01007697
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burdan Funeral Home FH83002461 13201 Wicker Ave., Cedar Lake, IN

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Lung CA	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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: Emphysema
- 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
- 29b. SIGNATURE AND TITLE OF CERTIFIER: C. M. Jabitan Jr. MD
- 29c. MEDICAL LICENSE NO.: 1002097OC
- 29d. DATE SIGNED (Month, Day, Year): 9-13-99
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): C. Labitan 9301 Wicker Ave. St John, IN 46356

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
- 32. DATE FILED (Month, Day, Year): September 14, 1999
- 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.

001337

CERTIFIED TRUE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

SEP 14 1999

900

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED

OCT 20 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

99064338

Beckman Kelly + Smith 5920 Hohman Ave. Hm. 46320

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

#47904