Key # 43-153-6
43-153-7

* 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. 99 0173

10CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

State No. 99008754

99 OCT 25 AM 10:19

RECORDER

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): Bruce Williams
2 SEX: Male
3a TIME OF DEATH: 6:22 A
3b DATE OF DEATH (Month Day Yr): March 4, 1999
4 *SOCIAL SECURITY NUMBER: 317-52-9199
5a AGE (Years): 51
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo. Day, Yr): June 24, 1947
7 BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
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 ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
9c CITY, TOWN OR LOCATION OF DEATH: Gary
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Shirley Morris
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Dispatcher
12b KIND OF BUSINESS/INDUSTRY: Gary Fire Department
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 1329 Clark Road
13e ZIP CODE: 46404
13f INSIDE CITY LIMITS: ☐ No XXX Yes
13g ON A FARM?: XX No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U S A
15 WAS DECEDENT OF HISPANIC ORIGIN?: XXX No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16 RACE—American Indian, Black, White, etc. (Specify): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): James G. Williams Sr.
19 MOTHER'S NAME (First Middle Maiden Surname): Ola Mae Bryant

INFORMANT

20a INFORMANT'S NAME (Type/Print): Shirley Williams
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1329 Clark Road Gary, Indiana 46404
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: XXXXX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): March 10, 1999 Oak Hill Cemetery
21c LOCATION—City or Town, State: Gary, Indiana
22a EMBALMER'S NAME: Rosenwald D. Allen Jr.
22b EMBALMER'S LICENSE NO: #29400047
23 WAS DEATH REPORTED TO CORONER?: XXX No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): #08700298
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704

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. Metabolic acidosis
DUE TO (OR AS A CONSEQUENCE OF)
b. Tumor lysis syndrome
DUE TO (OR AS A CONSEQUENCE OF)
c. Non-hodgkin's lymphoma, metastatic
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):

CERTIFIER

29a CERTIFIER (Check only one):
XXX ☒ 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: [signature] M.D.
29c MEDICAL LICENSE NO: 01042601
29d DATE SIGNED (Month Day Year): 3-10-1999
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): James Carter, Jr., M.D. 1600 Torrence Ave, Calumet City, IL 60409

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD m/h
FILED
32 DATE FILED (Month Day Year): MAR 16 1999

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month Day Year):
34b TIME OF INJURY:
34c INJURY AT WORK? (Yes or no):
34d DESCRIBE HOW INJURY OCCURRED: OCT 25 1999 9.00 E.P.
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): PETER BENJAMIN LAKE COUNTY AUDITOR CS
34g DATE PRONOUNCED DEAD (Month Day Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

001594

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