

ANDREY BUTLER
1453 W 18 Ave
Gary, IN 46409

91-0251

INDIANA STATE BOARD OF HEALTH RECORD

STATE OF INDIANA
LAKE COUNTY

No. 2000 0007190 DATE OF DEATH FEB - 1 PM State No.

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ONLY

1 DECEASED—NAME (First Middle Last) Doris Hall		2 SEX FEMALE		3a TIME OF DEATH 1:00a.m.		3b DATE OF DEATH (Month, Day, Yr.) March 20, 1991					
4 SOCIAL SECURITY NUMBER 438-32-0415		5a AGE—Last Birthday (Years) 64		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr.) November 1, 1926		7 BIRTHPLACE (City and State or Foreign Country) Shreveport, Louisiana	
8a WAS DECEDENT A US VETERAN? No		8b YEAR LAST SERVED IN US ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence							
9b FACILITY NAME (If not institution, give street and number) 2232 Chase Street				9c CITY, TOWN OR LOCATION OF DEATH Gary				9d COUNTY OF DEATH Lake			
10 MARITAL STATUS Widowed		11 SURVIVING SPOUSE (If wife, give maiden name) N/A		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 Residence			
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Gary		13d STREET AND NUMBER 2232 Chase Street					
13e ZIP CODE 46404		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) <input type="checkbox"/> College (1-4 or 5+) 12th	
18 FATHER'S NAME (First, Middle, Last) Louis Nicholson				19 MOTHER'S NAME (First, Middle, Maiden Surname) Maryliza Dickerson							
20a INFORMANT'S NAME (Type/Print) Wilbert Nicholson				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3642 Jackson Street Gary, Indiana 46408				20c Relationship Son			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 26, 1991 Oak Hill Cemetery				21c LOCATION—City or Town, State Gary, Indiana					
22a EMBALMER'S NAME Patrician Owens		22b EMBALMER'S LICENSE NO. #08700298		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) 08700298		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 83007704 Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404							
26 PART I Enter the disease, 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. Acute Coronary Occlusion Approximate Interval Between Onset and Death Acute DUE TO (OR AS A CONSEQUENCE OF) b. Ischemic Heart Disease 20 years DUE TO (OR AS A CONSEQUENCE OF) c. _____ 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. Hypertension 35 years											
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a WAS AN AUTOPSY PERFORMED? NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO							
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 TYPE OF CERTIFIER John T. Seubly MD				29c MEDICAL LICENSE NO. IN 17621		29d DATE SIGNED (Month, Day, Year) March 1991					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John T. Seubly MD 7895 Broadway Merrillville, IN 46410											
31 HEALTH OFFICER'S SIGNATURE Belva E. Foster MD MPH/AC						32 DATE FILED (Month, Day, Year) APR 5 1991					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED 00097			
34a PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)				34i. 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. END TRANS.							

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