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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

*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

Local No. 99-0868 CERTIFICATE OF DEATH State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER I.C. 16-37-1-3

2000 013651

2000 FEB 25 PM 2:05

JOHN M. MORRIS, W. CARTER
RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Luther K. Scott
2. SEX: Female
3a. TIME OF DEATH: 12:55
3b. DATE OF DEATH (Month, Day, Yr.): December 20, 1999
4. SOCIAL SECURITY NUMBER: 316-09-3212
5a. AGE—Last Birthday (Years): 89
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): May 28, 1910
7. BIRTHPLACE (City and State or Foreign Country): Boscoe, Louisiana
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; OTHER: DOA; X Nursing Home / Residence; Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 1941 Massachusetts Streets
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): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana 46402
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 1941 Mass. Street
13e. ZIP CODE: 46402
13f. INSIDE CITY LIMITS? X No / Yes
13g. ON A FARM? X No / Yes
14. WAS DECEDENT OF HISPANIC ORIGIN? X No / Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): U.S.A.
15. RACE—American Indian, Black, White, etc. (Specify): Black
16. 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): Archie Keaton
19. MOTHER'S NAME (First, Middle, Maiden Surname):

INFORMANT

20a. INFORMANT'S NAME (Type or Print): Dolores Bozeman
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 East 60th Drive Merrillville, IN 46410
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: X Burial / Cremation / Donation / Entombment / Removal from State / Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 23, 1999 Fern-Oak Cemetery
21c. LOCATION—City or Town, State: Griffith, IN
22a. EMBALMER'S NAME: Sherman Banks III
22b. EMBALMER'S LICENSE NO.: FDO 1016254
23. WAS DEATH REPORTED TO CORONER? X No / Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee): FDO 1016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034, 4209 Grant St. Gary, IN, 46408

CAUSE OF DEATH

PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter mode/special 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. Recurrent Metastatic Breast Cancer
Approximate Interval Between Onset and Death: 2 yrs
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Hypertension
27. WAS DECEDENT PREGNANT OR IN 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): 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:
29c. MEDICAL LICENSE NO: 01033117
29d. DATE SIGNED (Month, Day, Year): 01-04-2000
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Dr. B. Spotswood 636 East 21th Ave. Gary, Indiana 882-1555.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: MD, MPH
32. DATE FILED (Month, Day, Year): JAN 06 2000

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
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.

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SDH05-004 State Form 10110-05 (R4/3-93) Deathcer/PD 1