

\* 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.

70C + 3 Free VETS  
INDIANA STATE DEPARTMENT OF HEALTH

Local No. .... 97-0630

CERTIFICATE OF DEATH

State No. .... 2000

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Ezell Morris		2 SEX Male	3a TIME OF DEATH 6:45A M	3b DATE OF DEATH (Month, Day, Yr) September 9, 1997	
4 *SOCIAL SECURITY NUMBER 411-28-0313	5a AGE—Last Birthday (Years) 81	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) June 7, 1916	
7 BIRTHPLACE (City and State or Foreign Country) Blytheville, Arkansas					
8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
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) Lubertha Foster	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Second Helper		12b KIND OF BUSINESS/INDUSTRY USX Steel (South Work	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Merrillville	13d STREET AND NUMBER 5525 Jackson Street		
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U S A	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 (10-12) _____ College (13-16) _____					
18 FATHER'S NAME (First, Middle, Last) Eddie B. Morris		19 MOTHER'S NAME (First, Middle, Last, and Surname) Annie Sanders			
20a INFORMANT'S NAME (Type/Print) Lubertha Morris		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5525 Jackson Street Merrillville, Indiana 46410		20c Relationship Wife	
21a METHOD OF DISPOSITION <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) September 13, 1997 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licenses) #08700298	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Gly & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404		
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) Inoperable Brain Tumor DUE TO (OR AS A CONSEQUENCE OF) Cerebrovascular Accidents with Paresis, aphasia & Dysphagia DUE TO (OR AS A CONSEQUENCE OF) SEIZURES DUE TO (OR AS A CONSEQUENCE OF) Pneumonitis 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 Multiple Decubitus ulcers Coronary Artery Disease Hypertension					
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)	
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 TITLE OF CERTIFIER 		29c MEDICAL LICENSE NO. 31025	29d DATE SIGNED (Month, Day, Year) 9/15/97		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Bernadette Aghaja 4848 Broadway Gary, Indiana 46408					
31 HEALTH OFFICER'S SIGNATURE 			32 DATE FILED (Month, Day, Year) SEP 18 1997		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED 9:00 AM FEB 28 2000			
34g DATE PRONOUNCED DEAD (Month, Day, Year) VICTORIA Cape		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, give details PETER BENJAMIN LAKE COUNTY AUDITOR 5200 W. 21st Ave. Apt 104 Gary, In. 46406			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

NOT OFFICIAL!

This Document is the property of the Lake County Health Department

STATE OF INDIANA  
LAKE COUNTY  
HEALTH DEPARTMENT