* 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.

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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 96-0619

State No. #7-14-10

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): Jesse Jackson

2 SEX: Male

3a TIME OF DEATH: 11:00 A M

3b DATE OF DEATH (Month Day Yr): December 2, 1996

4 *SOCIAL SECURITY NUMBER: 410-26-9922

5a AGE—Last Birthday (Years): 73

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo. Day. Yr.): July 4, 1923

7 BIRTHPLACE (City and State or Foreign Country): Memphis, Tennessee

8a WAS DECEDENT A US VETERAN?: YES

8b YEAR LAST SERVED IN US ARMED FORCES?: 1945

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): 2443 Monroe Street

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): Eugenia DONALD

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Craneman

12b KIND OF BUSINESS/INDUSTRY: USX Steel Corp.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 2443 Monroe Street

13e ZIP CODE: 46407

13f INSIDE CITY LIMITS? ☐ Yes ☒ No

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): Black

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First Middle Last): (UNKNOWN) Jackson

19 MOTHER'S NAME (First Middle Maiden Surname): Jenny Ridley

INFORMANT

20a INFORMANT'S NAME (Type/Print): Eugenia Jackson

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2443 Monroe Street Gary, Indiana 46407

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): December 6, 1996 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? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Rosenwald D. Allen Jr.

24b LICENSE NUMBER (of Licensee): #08700646

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors Inc. #83007704 2959 W. 11th Avenue Gary, In 46404

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

IMMEDIATE CAUSE (Final disease or condition resulting in death): a Multiple Myeloma Sudden Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF): b Acute Congestive Heart Failure

Conditions if any which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c Coronary Heart Disease

DUE TO (OR AS A CONSEQUENCE OF): d Multiple Myeloma

Approximate Interval Between Onset and Death

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):
☒ 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: William F. Hawkins, M.D.

29c MEDICAL LICENSE NO: 022552

29d DATE SIGNED (Month Day Year): 12/3/96

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): William F. Hawkins M.D. 1205 Valparaiso IN 46383

31 HEALTH OFFICER'S SIGNATURE: William F. Hawkins M.D.

32 DATE FILED (Month Day Year): DEC 03 1996

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.: No