10CC

* **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.

STATE OF INDIANA
OFFICE OF VITAL RECORD
FILED

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 00 0169 2000 019171 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

2000 MAR 21 PM 1:47

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)			2. SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Mary	L.	Warren	Female	5:45 AM	February 26, 2000

4. *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months	Days	5c UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Mo. Day. Yr)	7 BIRTHPLACE (City and State or Foreign Country)
178-26-4685	67					July 29, 1932	Marvin, North Carolina

8a WAS DECEDENT A U S VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	HOSPITAL XXX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital Northlake	Gary	Lake

10 MARITAL STATUS (Specify)	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)	12b KIND OF BUSINESS/INDUSTRY
Married	W. Lovell Warren	Teacher	Gary Community School

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	1419 West 21st Avenue

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46407	XXX No ☐ Yes	XXX No ☐ Yes	U S A	XXX No ☐ Yes	Black		4 +

PARENTS

18 FATHER S NAME (First, Middle, Last)	19 MOTHER S NAME (First, Middle, Maiden Surname)
Clarence McCoy	Bessie Hardison

INFORMANT

20a INFORMANT S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
W. Lovell Warren	1419 West 21st Avenue Gary, Indiana 46407	Husband

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town, State
XXX Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	March 4, 2000 Evergreen Cemetery	Hobart, Indiana

22a EMBALMER S NAME	22b EMBALMER S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Rosenwald D. Allen Jr.	#29400047	XXX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
	#08700298	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 Cerebro vascular Accident

Conditions if any which gave rise to the immediate cause stating the underlying cause last
DUE TO (OR AS A CONSEQUENCE OF)
b
DUE TO (OR AS A CONSEQUENCE OF)
c
DUE TO (OR AS A CONSEQUENCE OF)
d

FILED
MAR 21 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

Transient Ischaemic attacks
Hypertension

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28 WAS AUTOPSY PERFORMED? (Yes or no)	29 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
Dr. S. Desai	01027933	3-13-00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
2640 Hennepin Rd Portage, IN 46368

HEALTH OFFICER

31 HEALTH OFFICER S SIGNATURE MD, MPH

32 DATE FILED (Month Day Year) MAR 15 2000

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				9.00

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
	C0413

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1