Key NO. 26-35-293-8

* **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.

Local No. 122

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF INDIANA
LAKE COUNTY
FILED

THIS CERTIFIES THE FOLLOWING IS A TRUE & COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

FEB 7 2000
Date Issued

Hammond Health Commissione

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): LEROY OVERSTREET
2 SEX: MALE
3a TIME OF DEATH: 1013 PM
3b DATE OF DEATH (Month Day Yr): FEB. 5, 2000
4 *SOCIAL SECURITY NUMBER: 401-20-0849
5a AGE—Last Birthday (Years): 75
5b UNDER 1 YEAR Months Days:
5c UNDER 1 DAY Hours Minutes:
6 DATE OF BIRTH (Mo Day Yr): DEC. 1, 1924
7 BIRTHPLACE (City and State or Foreign Country): KENTUCKY
8a WAS DECEDENT A U.S. VETERAN?: YES
8b YEAR LAST SERVED IN U.S. 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): ST. MARGARET MERCY
9c CITY TOWN OR LOCATION OF DEATH: HAMMOND
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): MARRIED
11 SURVIVING SPOUSE (If wife give maiden name): RUTH CARTER
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): BUTCHER
12b KIND OF BUSINESS/INDUSTRY: FOOD STORE
13a RESIDENCE—STATE: IN.
13b COUNTY: LAKE
13c CITY TOWN OR LOCATION: WHITING
13d STREET AND NUMBER: 1519 ROBERTS
13e ZIP CODE: 46394
13f INSIDE CITY LIMITS ☐ No ☑ Yes
13g ON A FARM? ☑ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☑ No ☐ Yes (If yes specify Cuban Mexican Puerto Rican etc.)
16 RACE—American Indian Black White etc (Specify): WHITE
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First Middle Last): ROOSEVELT MOORE
19 MOTHER'S NAME (First Middle Maiden Surname): IVA MAE BYERS

INFORMANT

20a INFORMANT'S NAME (Type/Print): RUTH
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 1519 ROBERTS WHITING, IN 46394
20c Relationship: WIFE

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☑ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): FEB. 7, 2000 ELMWOOD CEMETERY
21c LOCATION—City or Town State: HAMMOND, IN
22a EMBALMER'S NAME: T. OWENS
22b EMBALMER'S LICENSE NO: 1001049
23 WAS DEATH REPORTED TO CORONER? ☑ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: T. Owens
24b LICENSE NUMBER (of Licensee): 1001049
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FUNERAL HOME 7291 OWENS T.H. 816 119TH ST. WHITING, IN 46394

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 Persistent Bronchitis & Bronchospasm
DUE TO (OR AS A CONSEQUENCE OF)
b
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

Approximate Interval Between Onset and Death

FILED
MAR 22 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Sepsis · Severe Pneumonia · Leukopenia

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a WAS AUTOPSY PERFORMED?: 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: 033602821?
29d DATE SIGNED (Month Day Year): 2-7-00

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. ALEXANDER 13101 SO BALTIMORE, CHICAGO IL. 60633
31 HEALTH OFFICER'S SIGNATURE: Franklin D. Bermeda M.D.
32 DATE FILED (Month Day Year): February 7, 2000

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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): 00418
34g DATE PRONOUNCED DEAD (Month Day Year):
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

SDH06-004 State Form 10110 (R5/1-99)