

ATTENTION ESTATE: The Social Security # is requested by this state agency in order to issue its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

STATE OF INDIANA
LAKE COUNTY
INDIANA STATE DEPARTMENT OF HEALTH
500

State No. 98-0824.2000 026028
THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

1 DECEASED—NAME (First Middle Last) Bessie Garner		2 SEX Female	3a TIME OF DEATH 6:07 P M	3b DATE OF DEATH (Month Day, Yr) November 15, 1998
4 SOCIAL SECURITY NUMBER 311-26-4048	5a AGE—Last Birthday (Years) 92	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) July 23, 1906
7 BIRTHPLACE (City and State or Foreign Country) Cherokee, Alabama	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence		
9a FACILITY NAME (If not institution, give street and number) 1911 Massachusetts Street		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) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Server		12b KIND OF BUSINESS/INDUSTRY Canteen
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 1911 Massachusetts Street	
13e ZIP CODE 46407	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 (0-12) College (1-4 or 5+) 10th		18 FATHER'S NAME (First Middle Last) Sam Hayes		
19 MOTHER'S NAME (First Middle Maiden Surname) Molly Lightfoot		20a INFORMANT'S NAME (Type/Print) Alma M. Murphy		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Massachusetts Street Gary, Indiana 46407		20c Relationship Niece		
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) November 20, 1998 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Beaman</i>		24b LICENSE NUMBER (of Licensee) #08700646	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 83007704 Guy & Allen Funeral Directors, Inc 2959 W. 11th Avenue Gary, Indiana 46404	
26 PART I Enter the disease, 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 Organic Brain Syndrome		years
b Hypercholesterolemia		c Vertigo		years
d Peripheral Vascular Disease				years
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)
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> 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 my personal observation 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 <i>Thomas E. Cullins</i>		29c MEDICAL LICENSE NO 01030749	29d DATE SIGNED (Month Day Year) 11/24/98	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Dr Thomas Cullins 3290 Grant Street Gary, Indiana 46408				
31 HEALTH OFFICER'S SIGNATURE <i>Thomas E. Cullins MD MPH</i>			32 DATE FILED (Month Day Year) NOV 30 1998	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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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