ICU

Local No. 93-0337

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 022935

2000 APR -4 PM 1:00

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	Dorothy Davis
2 SEX	Female
3a TIME OF DEATH	3:51A M
3b DATE OF DEATH (Month, Day, Yr.)	April 23, 1993
4 SOCIAL SECURITY NUMBER	344-22-0753
5a AGE—Last Birthday (Years)	63
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo/Day/Yr.)	OCT 4, 1929
7 BIRTHPLACE (City and State or Foreign Country)	Muskegon, Michigan
8a WAS DECEDENT A U.S. VETERAN?	No
8b YEAR LAST SERVED IN US ARMED FORCES?	N/A
9a PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	424 Ellsworth Street
9c CITY, TOWN OR LOCATION OF DEATH	Gary
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Tommie Davis
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Housewife
12b KIND OF BUSINESS/INDUSTRY	Homemaker
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Gary
13d STREET AND NUMBER	424 Ellsworth Street
13e ZIP CODE	46404
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	Afro Am
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

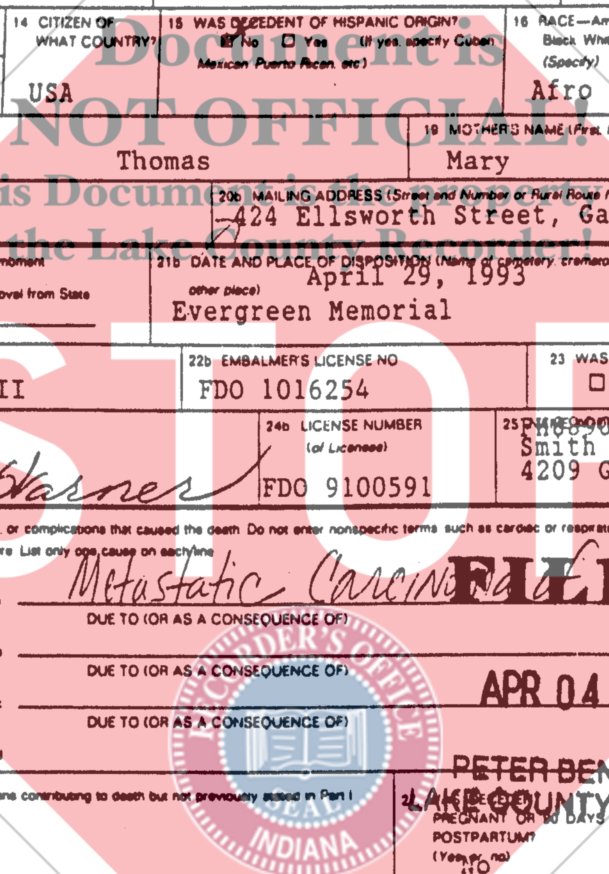
Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Hugh Thomas
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Mary Allen

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Tommie C. Davis
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	424 Ellsworth Street, Gary, Indiana 46404
20c Relationship	Husband

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	April 29, 1993 Evergreen Memorial
21c LOCATION—City or Town, State	Hobart, Indiana
22a EMBALMER'S NAME	Sherman G. Banks III
22b EMBALMER'S LICENSE NO	FDO 1016254
23 WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Paula R. Warner (signature)
24b LICENSE NUMBER (of Licensee)	FDO 9100591
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Smith Bizzell Warner & Son, 4209 Grant St., Gary, In. 46408



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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Metastatic Carcinoma Breast	10 years
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

FILED
APR 04 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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

Field	Entry
27 IF FEMALE, 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)	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.

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	Barbara L. Fuller M.D. (signature)
29c MEDICAL LICENSE NO	01039701
29d DATE SIGNED (Month, Day, Year)	4/27/93
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Barbara Fuller, 3229 Broadway, Gary, Indiana 46408

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	(signature)
32 DATE FILED (Month, Day, Year)	APR. 29 1993

CORONER USE ONLY

Field	Entry
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)	
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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SDH06 004 State Form 10110 (R3 / 3-92) DEATHCER