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MTC
504 Bdway Ste 523
Gary, In 46402

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.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. **97-0775**

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

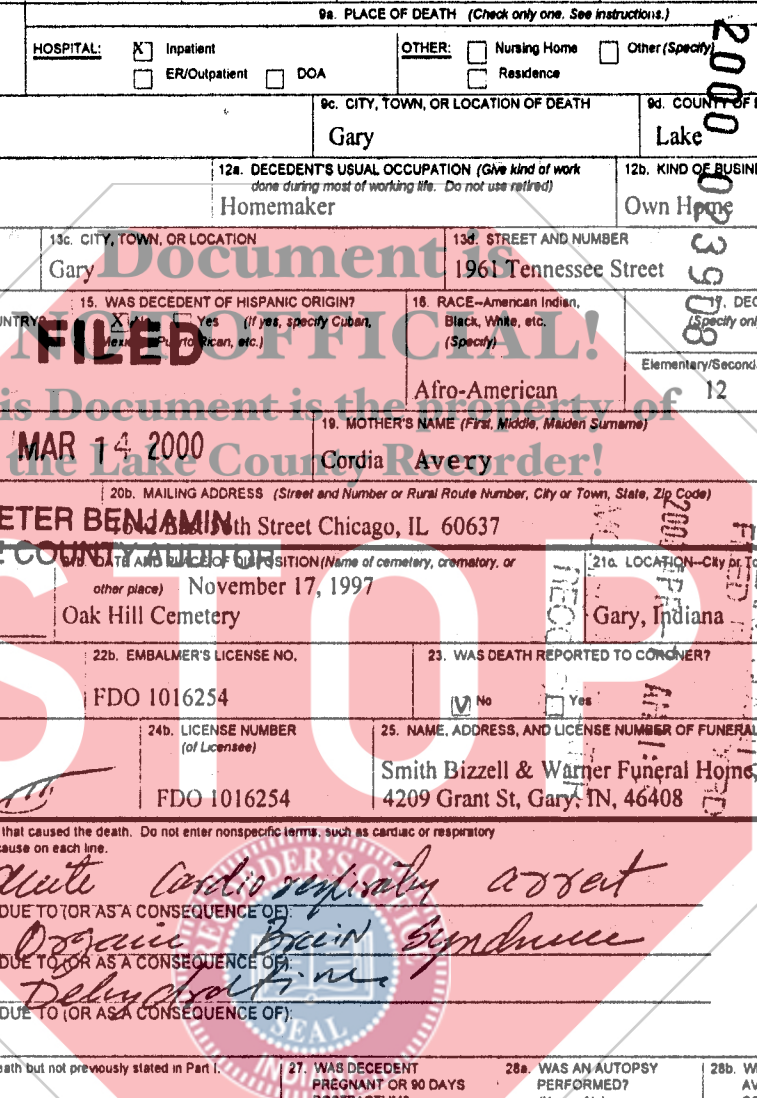
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) Lena M. Ewing		2. SEX Female	3a. TIME OF DEATH 10:30 A M	3b. DATE OF DEATH (Month, Day, Yr.) November 11, 1997	
4. SOCIAL SECURITY NUMBER 309-22-7868	5a. AGE-Last Birthday (Years) 87	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours MINUTES	6. DATE OF BIRTH (Mo, Day, Yr) October 27, 1910	
7. BIRTHPLACE (City and State or Foreign Country) Humboldt, Tennessee		8a. WAS DECEDENT A U.S. VETERAN? No			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) Gary Methodist Northlake		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)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE-STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 1961 Tennessee 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) Afro-American	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 12		18. FATHER'S NAME (First, Middle, Last) James D. Kenton			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Cordia Avery		20a. INFORMANT'S NAME (Type/Print) Gordon Bradshaw			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER BENJAMIN 11th Street Chicago, IL 60637		20c. Relationship Grandson			
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 17, 1997 Oak Hill Cemetery		21c. LOCATION-City or Town, State Gary, Indiana	
22a. EMBALMER'S NAME Sherman Banks III		22b. EMBALMER'S LICENSE NO. FDO 1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Sherman Banks III</i>		24b. LICENSE NUMBER (of Licensee) FDO 1016254	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner Funeral Home, #119600034 4209 Grant St, Gary, IN, 46408		
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. <i>Acute cardiovascular arrest</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Organic Brain Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Delirium</i> 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	
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) NO	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING 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 examination 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>[Signature]</i>		29c. MEDICAL LICENSE NO. C1026051	29d. DATE SIGNED (Month, Day, Year) 12/9/97		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Dr. V. Dave 3229 Broadway Gary, Indiana 46409					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) DEC 10 1997		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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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STATE OF INDIANA
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