* **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.

10CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 99-0180

State No. 2001

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Elmer Omega Langford

2 SEX: Female

3a TIME OF DEATH: 2:03 A M

3b DATE OF DEATH (Month, Day, Yr): July 3, 1999

4 *SOCIAL SECURITY NUMBER: 308-36-4966

5a AGE—Last Birthday (Years): 67

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): Montgomery, Alabama

8a WAS DECEDENT A U.S. VETERAN? NO

8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A

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): 709 Porter 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): Herman Langford

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Registered Nurse

12b KIND OF BUSINESS/INDUSTRY: St. Mary Medical Cente

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 709 Porter Street

13e ZIP CODE: 46406

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): Black

17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): 4 Years

PARENTS

18 FATHER'S NAME (First, Middle, Last): Nathaniel Blount Sr.

19 MOTHER'S NAME (First, Middle, Maiden Surname): Meller Spears

INFORMANT

20a INFORMANT'S NAME (Type/Print): Herman Langford

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 709 Porter Street Gary, Indiana 46406

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 9, 1999 Evergreen Cemetery

21c LOCATION—City or Town, State: Hobart, Indiana

22a EMBALMER'S NAME: Rosenwald D. Allen Jr.

22b EMBALMER'S LICENSE NO: #29400047

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR

24b LICENSE NUMBER (of Licensee): #08700298

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Cardiorespiratory failure — Approximate Interval Between Onset and Death: 24 hours
DUE TO (OR AS A CONSEQUENCE OF):
b. Rectal cancer — 7 months
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 13 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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)

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: Herdy Lee Kindler MD

29c MEDICAL LICENSE NO: 036-099370 (Illinois)

29d DATE SIGNED (Month, Day, Year): 7/15/99

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): HerdyLee Kindler MD University of Chicago 5841 S. Maryland Ave, MC 115 Chicago IL 60637

31 HEALTH OFFICER'S SIGNATURE

32 DATE FILED (Month, Day, Year): JUL 21 1999

33 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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): July 3, 1999

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

HOLD FOR FIRST AMERICAN TITLE

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

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