

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Return to: Atty Howard Grevitz
500 E. 86th Ave
Merrill, IN 46410

Local No. 96-0547 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

1. DECEASED-NAME (First Middle Last) Matilda Willa Hudson		2. SEX Female	3a. TIME OF DEATH 8:40AM	3b. DATE OF DEATH (Month Day Yr) August 23, 1996
4. SOCIAL SECURITY NUMBER 307-20-0549	5a. AGE - Last Birthday (Years) 78	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Sep 3, 1917
7. BIRTHPLACE (City and State or Foreign Country) Triana, AL 35758	8a. PLACE OF DEATH (Check only one. See instructions)			
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		
9b. FACILITY NAME (If not institution, give street and number) Methodist Northlake		9a. CITY TOWN OR LOCATION OF DEATH Gary	9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) NONE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Custodian	12b. KIND OF BUSINESS INDUSTRY Maintenance	
13a. RESIDENCE - STATE IN	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Gary	13d. STREET AND NUMBER 2448 Jackson Street	
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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 (Specify), Black, White, etc. Afro Amer
17. DECEDENT'S EDUCATION (Specify highest grade completed)		17. DECEDENT'S EDUCATION (Specify highest grade completed)		
Elementary/Secondary (9-12) 12		College (1-4 or 5+) 3		
18. FATHER'S NAME (First, Middle, Last) Willie Collier		18. MOTHER'S NAME (First Middle, Maiden Surname) JoAnn		
20a. INFORMANT'S NAME (Type/Print) Cecil G Goodson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 East 15th Avenue, Gary, IN 46407		20c. Relationship Son
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) Aug 28, 1996 Oak Hill Memorial Park		21c. LOCATION - City or Town State Gary, IN
22a. EMBALMER'S NAME Sherman G. Banks		22b. EMBALMER'S LICENSE NO. FDE1016254	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FDO1042607	24c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH88900011 Smith Bizzell & Warner 4209 Grant Street, Gary, IN 46408	
25. 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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>Metastatic Cancer</u> DUE TO (OR AS A CONSEQUENCE OF)				
b. _____ DUE TO (OR AS A CONSEQUENCE OF)				
c. _____ DUE TO (OR AS A CONSEQUENCE OF)				
d. _____ DUE TO (OR AS A CONSEQUENCE OF)				
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.				
27. WAS DECEDENT FREQUENT 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. 01041978		29d. DATE SIGNED (Month Day Year) 8-26-96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Dr H Macaballaw, 1619 West 5th Avenue, Gary, IN 46404				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month Day Year) AUG 27 1996
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		34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY/WORK? (Yes or no) 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) 9.00 PM		34g. DATE PRONOUNCED DEAD (Month Day Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. No		#1277A 14477		