1042

* 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.

2000 027907 2000 MAR 2[illegible] 2:28

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0412-00 State No.

38340

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): James E. Richardson
2 SEX: Male
3a TIME OF DEATH: 7:31P M
3b DATE OF DEATH (Month Day Year): January 31, 2000
4 SOCIAL SECURITY NUMBER: 227-42-9584
5a AGE—Last Birthday (Years): 64
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day Yr): Sep 27, 1935
7 BIRTHPLACE (City and State or Foreign Country): Stonega, Virginia
8a WAS DECEDENT A U.S. VETERAN? Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES? Unknown
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): 23919 Cline Ave.
9c CITY, TOWN, OR LOCATION OF DEATH: Lowell
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Clara Williams
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Foreman
12b KIND OF BUSINESS/INDUSTRY: Steel Mill
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Lowell
13d STREET AND NUMBER: 23919 Cline Ave.
13e ZIP CODE: 46356
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): White
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Anderson C. Richardson
19 MOTHER'S NAME (First Middle Maiden Surname): Pauline Smith

INFORMANT

20a INFORMANT'S NAME (Type/Print): Clara Richardson
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23919 Cline Ave. Lowell, IN 46356
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 4, 2000 Lake Village Cemetery
21c LOCATION—City or Town, State: Lake Village, IN
22a EMBALMER'S NAME: Molly A. Tucker Hawkins
22b EMBALMER'S LICENSE NO: ED09200061
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Ken Sheets
24b LICENSE NUMBER (of Licensee): FD08900045
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): Metastatic Ca[illegible]
DUE TO (OR AS A CONSEQUENCE OF)
DUE TO (OR AS A CONSEQUENCE OF)
DUE TO (OR AS A CONSEQUENCE OF)

Conditions if any which gave rise to the immediate cause stating the underlying cause last

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

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

FEB 15 2000

Alexander S. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
APR 2 - 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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: A.B. Benson III M.D.
29c MEDICAL LICENSE NO: 036-059058
29d DATE SIGNED (Month Day Year): 2-8-00
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. A. Benson, 676 N. St. Clair, Suite 850, Chicago, IL 60611

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.
32 DATE FILED (Month Day Year): February 15, 2000

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

9.00 E.R. CS

00631

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

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STOP