6 83 1 VETS

Key # 45-112-30

* 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. 3.28.00 ..... CERTIFICATE OF DEATH State No. .....

R-9129

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): Edmond J. Gardner

2 SEX: Male

3a TIME OF DEATH: 10:07 A M

3b DATE OF DEATH (Month, Day, Yr.): March 29, 2000

4 *SOCIAL SECURITY NUMBER: 427-24-5866

5a AGE--Last Birthday (Years): 83

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo. Day, Yr.): December 16, 1916

7 BIRTHPLACE (City and State or Foreign Country): Vicksburg, Mississippi

8a WAS DECEDENT A U.S. VETERAN? Yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946

9a PLACE OF DEATH (Check only one. See instructions.): HOSPITAL X Inpatient ER/Outpatient DOA; OTHER Nursing Home Residence; Other (Specify)

9b FACILITY NAME (If not institution, give street and number): St Mary's Medical Center

9c CITY, TOWN, OR LOCATION OF DEATH: Hobart

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Susan M. Taylor

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

12b KIND OF BUSINESS/INDUSTRY: USX

13a RESIDENCE--STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Gary

13d STREET AND NUMBER: 2339 Ohio Street

13e ZIP CODE: 46407

13f INSIDE CITY LIMITS: No X Yes

13g ON A FARM? X No Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? X 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): 8; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): John Gardner

19 MOTHER'S NAME (First, Middle, Maiden Surname): Dora Prentiss

INFORMANT

20a INFORMANT'S NAME (Type/Print): Susie M. Gardner

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2339 Ohio Street Gary, Indiana 46407

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: X Burial; Cremation; Entombment; Removal from State; Donation; Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 01, 2000 Evergreen Memorial Park

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

22a EMBALMER'S NAME: Sherman Banks III

22b EMBALMER'S LICENSE NO: FDO 1016254

23 WAS DEATH REPORTED TO CORONER? No Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Sherman Banks

24b LICENSE NUMBER (of Licensee): FDO 1016254

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF): b. Coronary artery disease

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death: a. b. c. d.

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

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

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: Harish Shah

29c MEDICAL LICENSE NO.: 01035471

29d DATE SIGNED (Month, Day, Year): 4-3-00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Harish Shah 58 East 86th Court Merrillville, IN

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Wilkinson MD

FILED

32 DATE FILED (Month, Day, Year): April 5, 2000

33 MANNER OF DEATH: Natural; Accident; Suicide; Homicide; Pending Investigation; Could not be Determined

34a DATE OF INJURY (Month, Day, Year): 3-16-2000

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.

PETER BENJAMIN LAKE COUNTY AUDITOR

A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

Alexander S. Wilkinson MD

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SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1

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