

Key # 43-105-19

INDIANA STATE BOARD OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 362

CERTIFICATE OF DEATH

APR 23 1990 Date Issued
Franklin D. Resendiz M.D. Hammond Health Commissioning

2000-043878

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

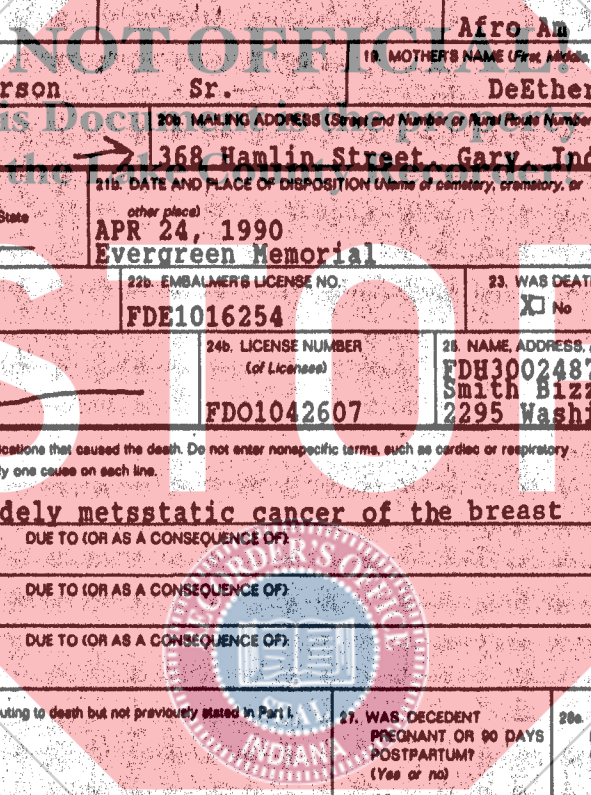
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) Mary Nell Bell		2. SEX Female	3a. TIME OF DEATH 12:00N M	3b. DATE OF DEATH (Month, Day, Year) April 20, 1990	
4. SOCIAL SECURITY NUMBER 317-36-9561	5a. AGE—Last Birthday (Years) 52	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) MAR 17, 1938	
7. BIRTHPLACE (City and State or Foreign Country) Edwards, Mississippi	8a. 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				
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9b. FACILITY NAME (If not institution, give street and number) St. Margaret			
9c. CITY, TOWN, OR LOCATION OF DEATH Hammond		9d. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) George Bell Jr.	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 368 Hamlin Street		
13e. ZIP CODE 46406	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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) Afro Am	
17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary (0-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Leroy Henderson Sr.			
18. MOTHER'S NAME (First, Middle, Maiden Surname) DeEther Phillips		19. INFORMANT'S NAME (Type/Print) George Bell Jr.			
20a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 368 Hamlin Street, Gary, Indiana 46406		20b. Relationship Husband			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) APR 24, 1990 Evergreen Memorial		21c. LOCATION—City or Town, State Hobart, Indiana	
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>Ed W...</i>		24b. LICENSE NUMBER (of License) FDO1042607		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FDH3002487 Smith Bizzell & Warner 2295 Washington St., Gary, In. 46407	
26. 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. widely metastatic cancer of the breast DUE TO (OR AS A CONSEQUENCE OF): b. _____ 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.					
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. 86259		29d. DATE SIGNED (Month, Day, Year) April 23, 90	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Dr. J. H. Gleaton 7905 Calumet Avenue, Munster, Indiana 46325					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) APRIL 23, 1990		
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 <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE MANNER OCCURRED 01848
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.			



FILED

APR 23 1990

Handwritten initials and date: JS- 9/20/05