Bee + Vet

Key No 25-46-274-2, 4, 5+6

*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

CERTIFICATE OF DEATH

Local No. 00 0433 State No.

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): Amos Thomas Atkins
2 SEX: Male
3a TIME OF DEATH: 9:43 A M
3b DATE OF DEATH (Month, Day, Yr): June 15, 2000
4 *SOCIAL SECURITY NUMBER: 415-46-0479
5a AGE--Last Birthday (Years): 68
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day, Yr): November 21, 1931
7 BIRTHPLACE (City and State or Foreign Country): Henning, Tennessee
8a WAS DECEDENT A U S VETERAN?: Yes
8b YEAR LAST SERVED IN U S ARMED FORCES?: 1954
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): Gary Methodist Northlake
9c CITY, TOWN, OR LOCATION OF DEATH: Gary
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Laverne Ligon
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Self-employed
12b KIND OF BUSINESS/INDUSTRY: Liquor Store Owner
13a RESIDENCE--STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Gary
13d STREET AND NUMBER: 5013 West 15th Avenue
13e ZIP CODE: 46406
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) College (1-4 or 5+): 12

PARENTS

18 FATHER'S NAME (First, Middle, Last): James Albert Atkins
19 MOTHER'S NAME (First, Middle, Maiden Surname): Katie Bell Holt

INFORMANT

20a INFORMANT'S NAME (Type/Print): Laverne Atkins
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5013 W. 15th Avenue Gary, IN 46406
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: X Burial; Cremation; Donation; Entombment; Removal from State; Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 19, 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: [signature]
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: Lung Cancer — Approximate Interval Between Onset and Death: 6 months
DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last b
DUE TO (OR AS A CONSEQUENCE OF)
c
DUE TO (OR AS A CONSEQUENCE OF)
d

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

FILED
JUN 27 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: [signature] MD
29c MEDICAL LICENSE NO: 01046157
29d DATE SIGNED (Month, Day, Year): 6/22/00
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Ebie 6111 Harrison Street Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD, MPH
32 DATE FILED (Month, Day, Year): JUN 22 2000

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

02060

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

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RECORDER'S OFFICE SEAL INDIANA