

ION ESTATE: The Social Security # is requested by this state agency in order to its statutory responsibility. Disclosure is tary and there will be no penalty for refusal. Local No. **00 0314**

INDIANA STATE DEPARTMENT OF HEALTH

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

CERTIFIER

HEAL OFFICER

1. DECEASED--NAME (First, Middle, Last) Juanita Wooden		2000 046045		2. SEX Female	3a. TIME OF DEATH JUN 21 11:45AM	3b. DATE OF DEATH (Month, Day, Yr.) April 25, 2000
4. SOCIAL SECURITY NUMBER 313-46-2801		5a. AGE--Last Birthday (Years) 57	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) August 06, 1942	7. BIRTHPLACE (City and State or Foreign Country) Brownsville, Tennessee
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a. 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				
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) 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) Cook		12b. KIND OF BUSINESS/INDUSTRY Resturant
13a. RESIDENCE--STATE Indiana		13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 3634 Johnson Street	
13e. ZIP CODE 46409	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A	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, Black, White, etc. (Specify) Black	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 12
18. FATHER'S NAME (First, Middle, Last) James Owens			19. MOTHER'S NAME (First, Middle, Maiden Surname) Nolia Owens			
20a. INFORMANT'S NAME (Type/Print) Harvey Perry		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3634 Johnson Street Gary, Indiana 46408			20c. Relationship Fiancee'	
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) April 29, 2000 Fern-Oak Cemetery		21c. LOCATION--City or Town, State Griffith, IN		
22a. EMBALMER'S NAME Sherman Banks III		22b. EMBALMER'S LICENSE NO. FDO 1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Sherman Banks</i>		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		
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. <u>Massive left cerebral infarction</u>				Approximate Interval Between Onset and Death
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. <u>Diabetes Mellitus</u>				
		c. <u>End stage Renal failure</u>				
		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
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>K. [Signature]</i>		29c. MEDICAL LICENSE NO. 01036576	29d. DATE SIGNED (Month, Day, Year) 5-1-00	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Umpathy 4802 Broadway Gary Indiana 46408						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) MAY 03 2000		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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 PROMULGATED (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT (Yes or no) If you specify driver, passenger, pedestrian, etc.				

H. Perry
3634 Johnson St
Gary IN

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