15 cc

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. 00 0219 ..... 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

1. DECEASED--NAME (First, Middle, Last)	2. SEX	3a TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Rev Dr. Cozetta L. Olive	Female	2:13 A M	March 20, 2000

4. SOCIAL SECURITY NUMBER	5a AGE--Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
314-30-1488	76			September 22, 1923	Coahoma, MS

8a. WAS DECEDENT A U S VETERAN?	8b. YEAR LAST SERVED IN U S ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No	N/A	HOSPITAL: X Inpatient; ER/Outpatient; DOA — OTHER: Nursing Home; Other (Specify); Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Gary Methodist Northlake	Gary	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	William M. Olive	Minister	AME Church

13a. RESIDENCE--STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Gary	2144 Tennessee St.

13e ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE--American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46407	No X Yes	No X Yes	USA	No X Yes	Black		5

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Henry Robinson	Mary Warner

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
William M. Olive	2144 Tennessee St. Gary, IN 46407	Husband

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION--City or Town, State
X Burial; Cremation; Entombment; Removal from State; Donation; Other (Specify)	March 25, 2000 Oak Hill Cemetery	Gary, IN

22a. EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Sherman Banks III	FDO 1016254	No Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Sherman Banks III	FDO 1016254	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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Lung Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):
b. Pulmonary Embolism

DUE TO (OR AS A CONSEQUENCE OF):
c. Pleural effusion

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or No)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
NO	NO	NO

FILED
JUL 24 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	01043017	3-27-00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. G. Onyeukwu 3290 Grant Gary Indiana 884-3447.

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE [signature] MD, MPH

32. DATE FILED (Month, Day, Year) MAR 28 2000

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c. INJURY AT WORK (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
Natural; Accident; Suicide; Homicide; Pending Investigation; Could not be Determined				

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.

00110

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

9.00 AM