12cc

* 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. 0226-00 State No. .....

385168

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) Benjamin Garner	2 SEX Male	3a TIME OF DEATH 4:07 P M	3b DATE OF DEATH (Month Day Yr) January 16, 2000		
4 *SOCIAL SECURITY NUMBER 427-54-2685	5a AGE—Last Birthday (Years) 65	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) July 26, 1934	7 BIRTHPLACE (City and State or Foreign Country) Booneville, MS
8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES?	8c 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) Methodist Hospital Southlake	9c CITY TOWN OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake 089			
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Georgia Fields	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Team leader	12b KIND OF BUSINESS/INDUSTRY U.S.X. Steel Corporation		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 1370 Baker Street		
13e ZIP CODE 46404	13f INSIDE CITY LIMITS [ ] No [X] 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) 12 College (1 4 or 5 +) 2+
	13g ON A FARM? [X] No [ ] Yes				

PARENTS

18 FATHER'S NAME (First Middle Last) George Garner	19 MOTHER'S NAME (First Middle Maiden Surname) Lilly Mae Owens

INFORMANT

20a INFORMANT'S NAME (Type/Print) Georgia Garner	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 1370 Baker Street Gary, Indiana 46404	20c Relationship Wife

DISPOSITION

21a METHOD OF DISPOSITION [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place) 1/20/00 Oak Hill Cemetary	21c LOCATION—City or Town State Gary, Indiana
22a EMBALMER'S NAME Rosenwald Allen, Jr.	22b EMBALMER'S LICENSE NO #29400047	23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee) #08700646	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704

CAUSE OF DEATH

26 PART I Enter the chain of diseases if any leading to the immediate cause Enter the underlying cause last Do not enter terminal events such as cardiac arrest 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 Metastatic Cholangiocarcinoma	4 Months
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 DUE TO (OR AS A CONSEQUENCE OF)	

JAN 26 2000

Alexander D. Hilkene, MD
LAKE COUNTY HEALTH COMMISSIONER

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

Cholangitis

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	

CERTIFIER

29a CERTIFIER (Check only one)

- [X] 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)
Barbara L Fuller, MD	01034701	1/20/00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEMS 26) (Type/Print) Barbara L. Fuller, M.D. 9305 So. Calumet Ave. Ste A1 Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE Alexander D. Hilkene, MD

32 DATE FILED (Month Day Year) January 26, 2000

FILED
JUL 28 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

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 [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

34e PLACE OF INJURY—At home farm street factory office building etc (Specify)	34f LOCATION (Street 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

01788

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

Key 43-154-18 43-154-2c 43-154-21

25 x