

\* 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.

4CC  
INDIANA STATE DEPARTMENT OF HEALTH

Local No. 99-0829 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

HEALTH  
OFFICER

1 DECEASED—NAME (First Middle Last) Ruth Glenette Hairston		2 SEX Female	3a TIME OF DEATH 3:01 P M	3b DATE OF DEATH (Month Day, Yr) November 29, 1999	
4 SOCIAL SECURITY NUMBER 2000-05-189 313-36-8826		5a AGE (Last, Middle, First) 62	5c UNDER (DAY) Months Days Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) February 15, 1937	
7 BIRTHPLACE (City and State or Foreign Country) Gary Indiana		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 type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution, give street and number) 544 Cleveland Street		9c CITY, TOWN, OR LOCATION OF DEATH Gary		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE Kenneth A. Hairston	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Teacher		12b KIND OF BUSINESS/INDUSTRY Gary Community School	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 544 Cleveland Street		
13e ZIP CODE 46402	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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) College (1-4 or 5+) 6 years		18 FATHER'S NAME (First, Middle, Last) Stanley Cotten			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Lula Mae Alexander		20a INFORMANT'S NAME (Type/Print) Kenneth A. Hairston			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 544 Cleveland Street Gary, Indiana 46404		20c Relationship Husband			
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) December 4, 1999 Fern Oak Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Roosevelt Allen Sr.		22b EMBALMER'S LICENSE NO. #01051696	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Broad</i>		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		
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) Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) Conditions if any which give rise to the immediate cause stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Ca Break sip mastectomy sip chemotherapy.					
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) -----					
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>Peter Benjamin</i>		29c MEDICAL LICENSE NO. 01035695	29d DATE SIGNED (Month, Day, Year) 12-6-99		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jyotsna Sanghvi, MD 8127 Merrillville Rd Merrillville, IN 46410					
31 HEALTH OFFICER'S SIGNATURE <i>Jyotsna Sanghvi</i>			32 DATE FILED (Month, Day, Year) DEC 0 0 1999		
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 PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			

FILED

AUG 8 2000

PETER BENJAMIN  
LAKE COUNTY AUDITOR

1085 AM 9.00

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