Calvin S. Hawkins
P.O. Box M859
Gary, In 46401

* 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.

Local No. 00 0243

10CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 47-352-45

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): Leander L. Uzzell	2. SEX: Male	3a. TIME OF DEATH: 2:45 PM	3b. DATE OF DEATH (Month, Day, Yr): March 29, 2000
4. *SOCIAL SECURITY NUMBER: 307-03-4379	5a. AGE—Last Birthday (Years): 88	5b. UNDER 1 YEAR (Months / Days) / 5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo, Day, Yr): November 14, 1911
7. BIRTHPLACE (City and State or Foreign Country): Terre Haute, 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 XXX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)	
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital 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): Thelma Adams	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: 2900 West 20th Place
13e. ZIP CODE: 46404	13f. INSIDE CITY LIMITS: ☐ No ☒ Yes; 13g. ON A FARM? XX No ☐ Yes	14. CITIZEN OF WHAT COUNTRY? U S A	15. WAS DECEDENT OF HISPANIC ORIGIN? XXXX 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+): 6 Years		

PARENTS

18. FATHER'S NAME (First, Middle, Last): David Uzzell	19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Brown

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Thelma Uzzell	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2900 West 20th Place Gary, Indiana 46404	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 5, 2000 Ridgelawn Cemetery	21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Jr.	22b. EMBALMER'S LICENSE NO.: #01051701	23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	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 82007704

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. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic airway obstruction
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertensive renal disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Pneumonia, CVA

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): 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):

FILED AUG 22 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

CERTIFIER

29a. CERTIFIER (Check only one)
XXXX 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: Odies H. Williams III, MD	29c. MEDICAL LICENSE NO.: 01026836A	29d. DATE SIGNED (Month, Day, Year): 4-6-2000

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Odies H. Williams III, M.D.

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD, MPH	32. DATE FILED (Month, Day, Year): APR 28 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.			

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