* 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.* 95-0801 State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Willie Joseph Sr.
2. SEX: Male
3a. TIME OF DEATH: 5:55 AM
3b. DATE OF DEATH (Month, Day, Yr): October 21, 1995
4. *SOCIAL SECURITY NUMBER: 437-09-0082
5a. AGE—Last Birthday (Years):
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): July 29, 1917
7. BIRTHPLACE (City and State or Foreign Country): Louisiana
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER XXXX Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Westside Health Care Center
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): Wille Mae Smith
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machine Helper
12b. KIND OF BUSINESS/INDUSTRY: Factory
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 309 Mathews Street
13e. ZIP CODE: 46406
13f. INSIDE CITY LIMITS: ☐ No XXXX Yes
13g. ON A FARM?: XXXX 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): 6th; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Theodoth Joseph
19. MOTHER'S NAME (First, Middle, Maiden Surname): Irena (Unknown)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Willie Mae Joseph
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 Mathews Street Gary, Indiana 46406
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XXXX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 26, 1995 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO: #01051696
23. WAS DEATH REPORTED TO CORONER?: XXXX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): #08700298
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 83007704 2959 W. 11th Avenue Gary, Indiana 46404

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): Cerebrovascular accident

DUE TO (OR AS A CONSEQUENCE OF): arteriosclerotic heart disease

DUE TO (OR AS A CONSEQUENCE OF): Generalised arteriosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Approximate Interval Between Onset and Death:

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PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Congestive Cardiac failure

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): ---

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: Krmnan Potti MD
29c. MEDICAL LICENSE NO: IN25043
29d. DATE SIGNED (Month, Day, Year): 10/25/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Krishnan Potti 8300 Broadway Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): OCT 27 1995

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.:

9.00 E.P. CS 01521

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

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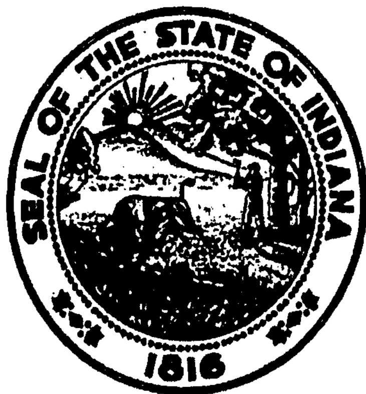

Official Stamp

2000 060710

STATE OF INDIANA
LAKE COUNTY
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MORRIS W. CARTER
RECORDER

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This is where you want the recorded document sent back to when it has completed the recording process.

Name Willie Mae Joseph

Address 309 Mathew St

City St Zip Gary Ind 46406

Telephone (219) 944-3843

Signature Printed ____________________

Signature Written ____________________

Date of Signature ____________________

Check Number ____________________

Check Amount ____________________

cash 9.00

Office Use Only

Check Equals Amount Due ☐ Yes ☐ No

Total ____________

Initials ____________