

*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. 1690-00

CERTIFICATE OF DEATH

State No.

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

58016 TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED-NAME (First, Middle, Last) Annie F. Moss		2. SEX Female		3a. TIME OF DEATH 6:55 P		3b. DATE OF DEATH (Month, Day, Yr.) June 30, 2000	
4. SOCIAL SECURITY NUMBER 311-26-1663		5a. AGE--Last Birthday (Years) 78		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr.) September 01, 1921		7. BIRTHPLACE (City and State or Foreign Country) Tuskegee, Alabama					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake				9b. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) None		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Feeder		12b. KIND OF BUSINESS/INDUSTRY Container Corp.	
13a. RESIDENCE--STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Merrillville		13d. STREET AND NUMBER 8040 Chapel Drive	
13e. ZIP CODE 46410		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) <input checked="" type="checkbox"/> 3 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Henry Pullium					
19. MOTHER'S NAME (First, Middle, Maiden Surname) Gracie Harper		20. INFORMANT'S NAME (Type/Print) Beatrice C. Eddie					
20a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8040 Chapel Drive Merrillville, Indiana 46410		20b. Relationship Daughter					
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) July 07, 2000 Fern Oaks Cemetery		21c. LOCATION--City or Town, State Griffith, Indiana			
22a. EMBALMER'S NAME Sherman Banks III		22b. EMBALMER'S LICENSE NO. FDO 1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Sherman Banks III</i>		24b. LICENSE NUMBER (of Licensee) FDO 1016254		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner Funeral Home, FH19600034 4209 Grant St, Gary, IN, 46408			
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) CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No		28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) No		Approximate Interval Between Onset and Death 1 1/2 YRS.	
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. LYMPHOMA		29. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No		28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) No		Approximate Interval Between Onset and Death 1 1/2 YRS.	
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>Alexander Williams MD</i>		29c. MEDICAL LICENSE NO. 01030107		29d. DATE SIGNED (Month, Day, Year) 7-18-2000	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29b) (Type/Print) Dr. Barai 125 East 89th Merrillville, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>		32. DATE FILED (Month, Day, Year) July 21, 2000					
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. PLACE OF INJURY--At home, farm, street, factory, office building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) JUL 21 2000					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT (Yes or no) If yes specify driver, passenger, pedestrian, etc. <i>Alexander Williams MD</i>					

PARENTS INFORMANT

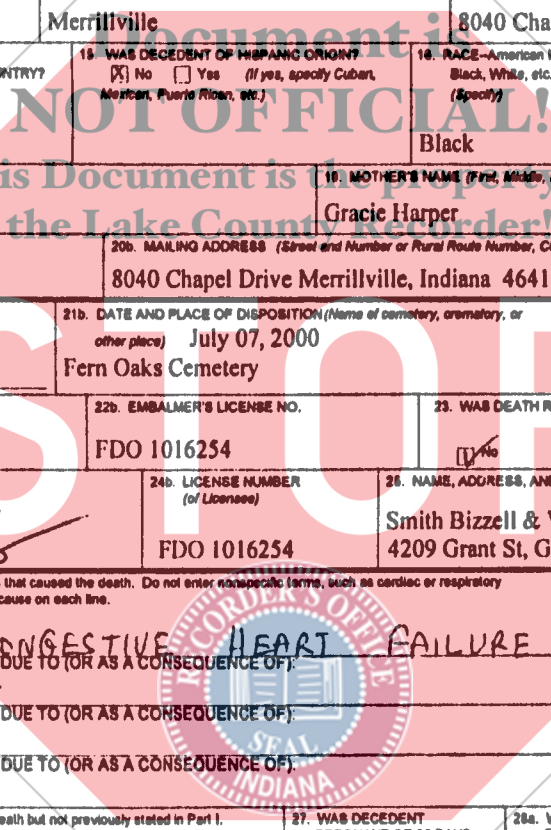
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Jeffery A. Rivera 1014 E. 90th St. Merrillville 46410



403/97H