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. 2074-97

INDIANA STATE DEPARTMENT OF HEALTH

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

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	JOE M. RANDOLPH
2. SEX	MALE
3a. TIME OF DEATH	11:50 PM
3b. DATE OF DEATH (Month, Day, Yr)	OCTOBER 6, 1997
4. SOCIAL SECURITY NUMBER	238-52-1899
5a. AGE—Last Birthday (Years)	63
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	March 31, 1934
7. BIRTHPLACE (City and State or Foreign Country)	Cleveland Co., NC
8a. WAS DECEDENT A U.S. VETERAN?	no
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	no
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number)	Residence: 4303 W. 45th Avenue
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)	Patricia A. Main
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Carpenter
12b. KIND OF BUSINESS/INDUSTRY	Combustion Engineering
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary
13d. STREET AND NUMBER	4303 W. 45th Avenue
13e. ZIP CODE	46408
13f. INSIDE CITY LIMITS	☒ No ☐ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	8

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Wilson Randolph
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Carrie Mae Whitemer

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Mrs. Patricia A. Randolph
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4303 W. 45th Avenue Gary, IN 46408
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	October 9, 1997 Northwest Indiana Cremation Serv.
21c. LOCATION—City or Town, State	Crown Point, IN
22a. EMBALMER'S NAME	none
22b. EMBALMER'S LICENSE NO	none
23. WAS DEATH REPORTED TO CORONER?	☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FD01013507
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Coronary artery disease	
DUE TO (OR AS A CONSEQUENCE OF) b.	Chronic renal failure	
DUE TO (OR AS A CONSEQUENCE OF) c.	Generalized arteriosclerosis	
DUE TO (OR AS A CONSEQUENCE OF) d.		

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

Field	Entry
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)	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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Shannon K McCarthy MD
29c. MEDICAL LICENSE NO	0108 1401
29d. DATE SIGNED (Month, Day, Year)	10/7/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Shannon K. McCarthy, M.D. 9117 Broadway Suite N Merrillville, IN 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD
32. DATE FILED (Month, Day, Year)	October 8, 1997
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.	

THIS CERTIFIES THE ABOVE IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. 01348

OCT 08 1997 9 am

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED 2000 SEP 22 PM 2:26 FILED FOR RECORD
PETER BENJAMIN LAKE COUNTY AUDITOR
STATE OF INDIANA LAKE COUNTY

2000 062226

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

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