3 cts 1.0 C

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 95-0915

CERTIFICATE OF DEATH STATE OF INDIANA

State No. #44-2425

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

LAKE COUNTY FILED FOR RECORD

2000 OCT 2 PM 2:47

MICHAEL B. BROWN RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): PEARSON CAMPBELL 2000 071500
2. SEX: Male
3a. TIME OF DEATH: 10:58 AM
3b. DATE OF DEATH (Month, Day, Yr.): November 30, 1995
4. SOCIAL SECURITY NUMBER: 428-48-7815
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.): July 7, 1932
7. BIRTHPLACE (City and State or Foreign Country): Starksville, Mississippi
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1955
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): 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): Willa V. Pope
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Shipping Clerk
12b. KIND OF BUSINESS/INDUSTRY: Health & Beauty Aid
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 111 Marshall Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Eddie Campbell
19. MOTHER'S NAME (First, Middle, Maiden Surname): Allee Pearson Campbell

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Willa V. Campbell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Marshall Street Gary, IN 46404
20c. Relationship: wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Dec. 5, 1995 Oakland Memory
21c. LOCATION—City or Town, State: Dolton, Illinois
22a. EMBALMER'S NAME: Paul Anthony Robinson
22b. EMBALMER'S LICENSE NO.: 1017284
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Paul Anthony Robinson
24b. LICENSE NUMBER (of Licensee): 1017284
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: House of Robinson Funeral Directors 1900 W. 15th Ave. - Gary, IN 46404 19500007

FILED OCT 2 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

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):
a. Vascular collapse
DUE TO (OR AS A CONSEQUENCE OF):
b. Due to arteriosclerotic heart and vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death: Unknown

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):

CERTIFIER

29a. CERTIFIER (Check only one): Deputy
☐ 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: Donna Melyon
29c. MEDICAL LICENSE NO: N/A
29d. DATE SIGNED (Month, Day, Year): December 1, 1995

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): DEC 04 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: 00118 9.00
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) E.P. CS
34g. DATE PRONOUNCED DEAD (Month, Day, Year): November 30, 1995
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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

2000 071503

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 OCT -2 PM 2:47

MORRIS W. CARTER
RECORDER

Document Mail Back to Information Sheet

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

Name Willa Campbell

Address 1200 Washington St.

City St Zip Gary, In. 46407

Telephone _____

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 _____