gcc

INDIANA STATE BOARD OF HEALTH

Local No. 96-90

CERTIFICATE OF DEATH

State No. .....

STATE OF INDIANA
LAKE COUNTY
FILED

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last): Leonettza Latimer	2. SEX: Female	3d. TIME OF DEATH: 9:32 A M	3b. DATE OF DEATH (Month, Day, Yr.): April 30, 1990			
4. SOCIAL SECURITY NUMBER: 334-12-1277	5a. AGE—Last Birthday (Years): 2000	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day, Yr.): Jan 25 1917	7. BIRTHPLACE (City and State or Foreign Country): Hopkinsville, Ky.	
8a. WAS DECEDENT A U.S. VETERAN?: N/A	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	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 Southlake	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): William Latimer	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker	12b. KIND OF BUSINESS/INDUSTRY			
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Gary	13d. STREET AND NUMBER: 2335 Monroe St.			
13e. ZIP CODE: 46407	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): / College (1-4 or 5 +): 5+
18. FATHER'S NAME (First, Middle, Last): Marcellus Washington	19. MOTHER'S NAME (First, Middle, Maiden Surname): Madie Unavailible					
20a. INFORMANT'S NAME (Type/Print): William Latimer	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2335 Monroe St.	20c. Relationship: Husband				
21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 4, 1990 Evergreen	21c. LOCATION—City or Town, State: Hobart, IN				
22a. EMBALMER'S NAME: Russel A. Ennols	22b. EMBALMER'S LICENSE NO.: 1008847	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: Ennols & Robinson Mem Chpl. 1900 W. 15th Ave. Gary, IN 300249				

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. Cardiac Arrest	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Severe End Stage Cardiomyopathy	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	N/A

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
MD.	01026059	5/3/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Arun K. Goel M.D. 209 East 86th Ct. Merrillville, Indiana

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year): 5/7/90

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

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
OCT 10 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

34e. PLACE OF INJURY (Home, street, factory, office building, etc. (Specify))	34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
OCT 10 2000	

34g. DATE PRONOUNCED DEAD (Month, Day, Year): OCT 10 2000

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

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SBH06-004 State Form 10100 (R2 / 5-90) PRO 1

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Information Sheet

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

Name: TERESA Latimer

Address: 3700 Johnson

City St Zip: Gary IN 46408

Telephone: (219)-923-9975

Signature Printed: /

Signature Written: Teresa Latimer

Date of Signature: 10/10/00

Check Number: CK # 3446 / DC

Check Amount: $ 26.00 tott.

Office Use Only

Check Equals Amount Due ☐Yes ☐No

Total _____

Initials _____