

\* 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. **01 0863**

State No. ....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>Richard Fuller</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>8:00p</b>	3b DATE OF DEATH (Month, Day, Yr) <b>December 27, 2001</b>	
4 *SOCIAL SECURITY NUMBER <b>416-52-7396</b>	5a AGE—Last Birthday (Years) <b>81</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>May 1, 1920</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Livingston, Al.</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>No</b>	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) <b>1330 Cass St.</b>		9c CITY, TOWN OR LOCATION OF DEATH <b>Gary</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Widow</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>n/a</b>	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Construction Worker</b>		12b KIND OF BUSINESS/INDUSTRY <b>General</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Gary</b>		13d STREET AND NUMBER <b>829 Delaware St.</b>	
13e ZIP CODE <b>45407</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>BLACK</b>	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) _____			18 FATHER'S NAME (First, Middle, Last) <b>Dan Pratt</b>		
19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Unknown</b>			20a INFORMANT'S NAME (Type/Print) <b>Adriane Wheeler</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1330 Cass St. Gary, In. 46402</b>			20c Relationship <b>Daughter</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>January 4, 2002 Fern Oak Cemetery</b>		21c LOCATION—City or Town, State <b>Griffin, In.</b>	
22a EMBALMER'S NAME <b>Leon Coleman Jr.</b>		22b EMBALMER'S LICENSE NO. <b>4523</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Leon Coleman</i>		24b LICENSE NUMBER (of Licensee) <b>104-5231</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Powell-Coleman Funeral Home 1901 Washington St. Gary, In. 46402-434</b>		
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. <b>Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>Cancer &amp; Ampullae of Vater</b> DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.					
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) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>		
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 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 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>Peter Benjamin</i> <b>Lake County Auditor</b>		29c MEDICAL LICENSE NO. <b>01033014</b>	29d DATE SIGNED (Month, Day, Year) <b>1/7/02</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Oketch N. NABAKA 3535 Broadway Gary, Indiana 46402</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Walter M. M.P.</i>				32 DATE FILED (Month, Day, Year) <b>JAN 6 2002</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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) <b>9.00</b>		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>001295</b>			

Unit # 25  
Key # 44-16-12  
Gary Land Co's 1st Sub lot 12 Block 16

