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K# 43-204-410

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1825-93

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

1. DECEASED—NAME (First, Middle, Last): Mary E Larry
2. SEX: female
3a. TIME OF DEATH: 9:50 p M
3b. DATE OF DEATH (Month, Day, Yr): July 18, 1993
4. SOCIAL SECURITY NUMBER: 496-12-3078
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo. Day. Yr): November 7,1919
7. BIRTHPLACE (City and State or Foreign Country): Tallahassee,Mississipp
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: XXX ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Munster Med Inn
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Beautician
12b. KIND OF BUSINESS/INDUSTRY: Self employed
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 1929 Carolina Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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 +): 4 Years

PARENTS

18. FATHER'S NAME (First, Middle, Last): Steven Taylor
19. MOTHER'S NAME (First, Middle, Maiden Surname): Willie Tenant

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Brenda Murphy
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1549 Bigger Street Gary, Indiana 46404
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 23, 1993 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO. (of Licensee): #01051701
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Pat
24b. LICENSE NUMBER (of Licensee): #08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ~~83007704~~ Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary,Indiana46404

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. Metastatic Adeno Carc

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

Approximate Interval Between Onset and Death:

JUL 27 1993

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Hypertension, Congenital intestinal obstruction

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. MEDICAL LICENSE NO.: 010277498
29d. DATE CERTIFIED (Month, Day, Year): 7/19/93

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOHN F. PEREZ M.D. 7905 Calumet Ave. Munster IN 46321
31. HEALTH OFFICER'S SIGNATURE: MD
32. DATE FILED (Month, Day, Year): July 27, 1993

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED: 000307
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.:

9.00 AK 11

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD 1

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