

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.

6CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 2764-01

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

USE OF PATH

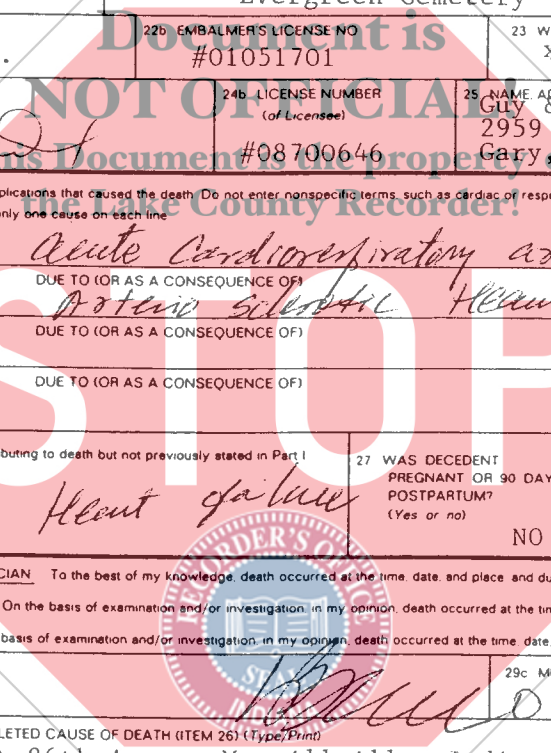
CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Elzie M. <b>2002 038481</b>		2 SEX Female	3a TIME OF DEATH 2:05 pm	3b DATE OF DEATH (Month, Day, Yr.) October 27, 2001
4 *SOCIAL SECURITY NUMBER 408-62-7889	5a AGE—Last Birthday (Years) 75	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month, Day, Year) November 28, 1925
7 BIRTHPLACE (City and State or Foreign Country) Alamo, Tennessee	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 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA RESIDENCE <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)	
9b FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c CITY, TOWN OR LOCATION OF DEATH Hobart	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) High W. Brown	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Teacher	12b KIND OF BUSINESS/INDUSTRY Gary Public Schools	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 4014 West 11th Avenue	
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) 4		18 FATHER'S NAME (First, Middle, Last) R. L. Mitchell		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Coops		20a INFORMANT'S NAME (Type/Print) High W. Brown		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 West 11th Avenue Gary, Indiana 46404		20c Relationship Husband		
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) November 2, 2001 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, Indiana
22a EMBALMER'S NAME Roosevelt Allen Jr.		22b EMBALMER'S LICENSE NO. #01051701		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) #08700646		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Director 2959 West 11th Avenue Gary, Indiana 46404 83007704
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 <i>Acute Cardiorespiratory arrest</i> b <i>Arterio-sclerotic Heart Disease</i> c d				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Coronary Heart disease</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)
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 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 <input type="checkbox"/> 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 <i>[Signature]</i>			29c MEDICAL LICENSE NO. 01026051	29d DATE SIGNED (Month, Day, Year) 11-9-01
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Dr. Dave 200 East 86th Avenue Merrillville, Indiana 46410				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				
32 DATE FILED (Month, Day, Year) November 14, 2001				
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide				
34a DATE OF INJURY (Month, Day, Year) APR 23 2002		34b TITLE OF INJURY		
34c PLACE OF INJURY (Home, farm, factory, office, building, etc. (Specify))		34d INJURY-AT-WORK FILE WITH THE EMPLOYER (Yes or no) NO		
34e PLACE OF INJURY (Home, farm, factory, office, building, etc. (Specify))		34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 275 W. 11th		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h SIGNATURE AND TITLE OF AUDITOR PETER BENJAMIN LAKE COUNTY AUDITOR		

Gary Heights lots 22423 of E2ft of lot 24, Block 22, Unit #25 Key # 43-176-22, Unit #25

Robert L. Lewis & Assoc. 2148 W. 11th Ave. Gary, IN 46404



FILED APR 23 2002

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