

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 46-552-38  
CERTIFICATE OF DEATH State No. ....

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

Local No. 2851-01

393368  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle Last) **Jesse McNeal** 2 SEX **Male** 3a TIME OF DEATH **5:15 P.M.** 3b DATE OF DEATH (Month Day Yr.) **November 19, 2001**

4 \*SOCIAL SECURITY NUMBER **317-20-8671** 5a AGE—Last Birthday (Years) **74** 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Mo Day Yr) **January 19, 1927** 7 BIRTHPLACE (City and State or Foreign Country) **Gary, Indiana**

8a WAS DECEDENT A U.S. VETERAN? **Yes** 8b YEAR LAST SERVED IN U.S. ARMED FORCES? **1941** 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) **Southlake Nursing Home** 9c CITY, TOWN OR LOCATION OF DEATH **Merrillville** 9d COUNTY OF DEATH **Lake**

10 MARITAL STATUS (Specify) **Married** 11 SURVIVING SPOUSE (if wife, give maiden name) **Essie** 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Steel Mill** 12b KIND OF BUSINESS/INDUSTRY **Inland Steel**

13a RESIDENCE—STATE **Indiana** 13b COUNTY **Lake** 13c CITY, TOWN OR LOCATION **Gary** 13d STREET AND NUMBER **2614 E. 22nd PL.**

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) **11th**

18 FATHER'S NAME (First Middle Last) **Curtis McNeal** 19 MOTHER'S NAME (First Middle Maiden Surname) **Hertha Gibbs**

20a INFORMANT'S NAME (Type/Print) **Essie McNeal** 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **2614 E. 22nd Pl. Gary, IN 46407** 20c Relationship **Wife**

21a METHOD OF DISPOSITION  Burial  Cremation  Entombment  Removal from State  Donation  Other (Specify) 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **REGIONAL Crematory** 21c LOCATION—City or Town State **GARY, IN.**

22a EMBALMER'S NAME **D. Lee Cammack** 22b EMBALMER'S LICENSE NO. **FD20000021** 23 WAS DEATH REPORTED TO CORONER?  No  Yes

24a SIGNATURE OF FUNERAL DIRECTOR *[Signature]* 24b LICENSE NUMBER (of licensee) **FD20000021** 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME **Serenity Gardens Funeral Home 934 E. 21st Ave., Gary, IN 46407**

26 PART I COMPLETE CAUSE OF DEATH (List all causes of death. Do not enter nonspecific terms, such as cardiac or respiratory. List causes on each line.)

IMMEDIATE CAUSE (Final disease or condition resulting in death) **CANCER - THROAT & NECK** Approximate Interval Between Onset and Death **MAY 01 2002**

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) **No** 28a WERE AUTOPSY FINDINGS PERFORMED? (Yes or no) **No** 28b WERE AUTOPSY FINDINGS REPORTED TO COMPLETION OF CAUSE OF DEATH? (Yes or no) **No**

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) as stated.

29b SIGNATURE AND TITLE OF CERTIFIER *[Signature]*

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Dr. Stemer 761 45th St. Munster, IN 46321** 29c MEDICAL LICENSE NO. **01025591** 29d DATE SIGNED (Month Day Year) **11-26-01**

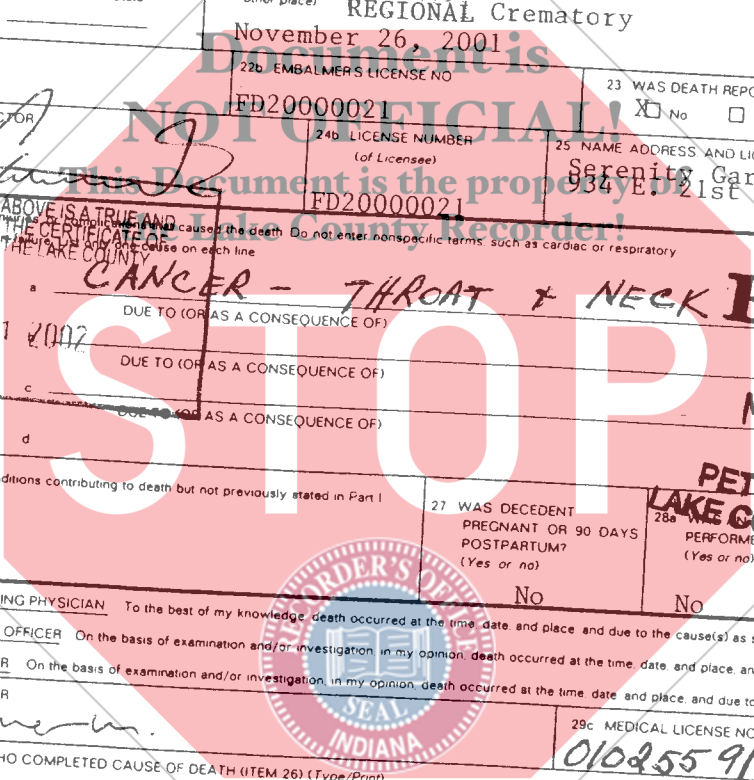
31 HEALTH OFFICER'S SIGNATURE *[Signature]* 32 DATE FILED (Month Day Year) **November 26, 2001**

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

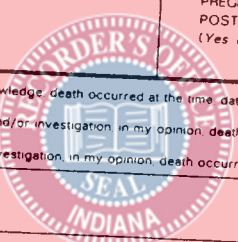
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 34f LOCATION (Street and Number or Rural Route Number, City or Town, State) **BD 900 Cash**

34g DATE PRONOUNCED DEAD (Month Day Year) 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.



**FILED**  
MAY 01 2002

**PETER BENJAMIN LAKE COUNTY AUDITOR**



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER