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

Local No. 2851-01 State No. .....

39336X

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Jesse McNeal

2002 041081

2 SEX: Male

3a TIME OF DEATH: 5:15 P.M. 12:52

3b DATE OF DEATH (Month, Day, Yr.): November 19, 2001

4 *SOCIAL SECURITY NUMBER: 317-20-8671

4a 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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [X] 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 [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? USA

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 11th; College (1-4 or 5 +)

PARENTS

18 FATHER'S NAME (First, Middle, Last): Curtis McNeal

19 MOTHER'S NAME (First, Middle, Maiden Surname): Hertha Gibbs

INFORMANT

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

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): REGIONAL Crematory, November 26, 2001

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? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: D. Lee Cammack

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, FH10000003

CAUSE OF DEATH

26 PART I. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH OFFICER. THIS CERTIFIES THE ABOVE IS A TRUE AND [illegible]

Enter the chain of events—diseases, injuries, or complications—that directly caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. Report only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. CANCER - THROAT & NECK

DUE TO (OR AS A CONSEQUENCE OF): b.

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I

FILED MAY 01 2002 PETER BENJAMIN LAKE COUNTY AUDITOR

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No

28a WAS AUTOPSY PERFORMED? (Yes or no): No

28b WERE AUTOPSY FINDINGS CONSIDERED PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

CERTIFIER

29a CERTIFIER (Check only one): [X] 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: [signature]

29c MEDICAL LICENSE NO: 01025591

29d DATE SIGNED (Month, Day, Year): 11-26-01

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Stemer 761 45th St. Munster, IN 46321 922-3002

(00126

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.

32 DATE FILED (Month, Day, Year): November 26, 2001

33 MANNER OF DEATH: [X] 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

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.

BD 9.00 Cash