

* 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

State No.

Local No. 00 0439

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

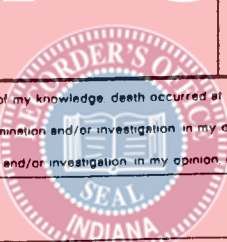
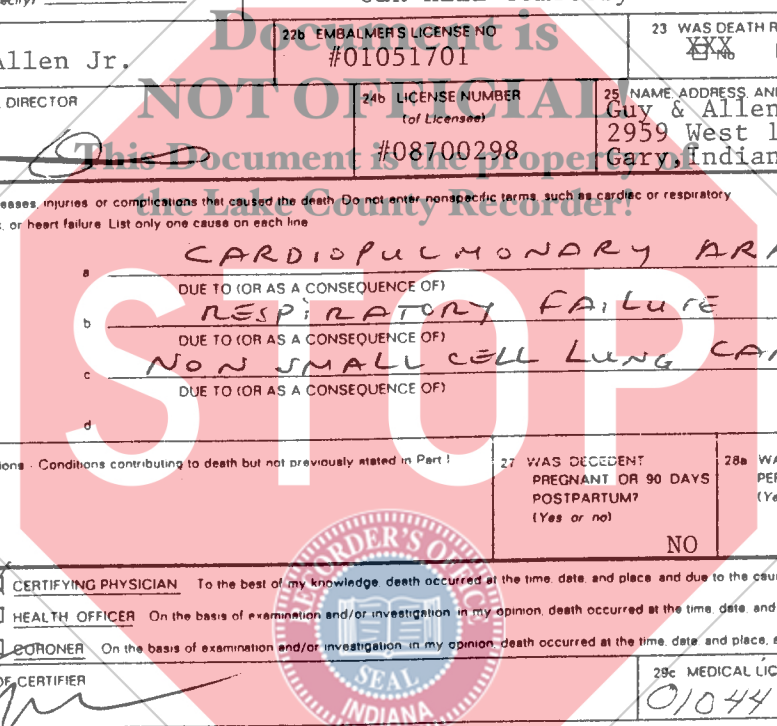
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) John 2002 042002 Parker			2 SEX Male		3 TIME OF DEATH 4:21 P M		3b DATE OF DEATH (Month Day, Yr) September 19, 2000		
4 *SOCIAL SECURITY NUMBER 427-54-9272			5a AGE—Last Birthday (Years) 68		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		
6 DATE OF BIRTH (Mo. Day, Yr) July 7, 1932			7 BIRTHPLACE (City and State or Foreign Country) Grenada, Mississippi						
8a WAS DECEDENT A US VETERAN? YES		8b YEAR LAST SERVED IN US ARMED FORCES?		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution give street and number) Methodist Hospital Northlake				9c CITY, TOWN, OR LOCATION OF DEATH Gary			9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Prince O. Cannon		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Craneman			12b KIND OF BUSINESS/INDUSTRY USX Steel Corp.		
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Gary			13d STREET AND NUMBER 451 Taft Street		
13e ZIP CODE 46404		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U S A		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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5 +) <input type="checkbox"/>		17 12th		18 FATHER'S NAME (First Middle, Last) Osby Parker		19 MOTHER'S NAME (First Middle, Maiden Surname) Bobbie Dunn			
20a INFORMANT'S NAME (Type/Print) Prince O. Parker				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Taft Street Gary, Indiana 46404			20c Relationship Wife		
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) September 25, 2000 Oak Hill Cemetery				21c LOCATION—City or Town, State Gary, Indiana		
22a EMBALMER'S NAME Roosevelt Allen Jr.			22b EMBALMER'S LICENSE NO. #01051701			23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
24a SIGNATURE OF FUNERAL DIRECTOR			24b LICENSE NUMBER (of Licensee) #08700298		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704				
26 PART I Enter the diseases, injuries or complications that caused the death. Do not enter non-specific 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 <u>CARDIOPULMONARY ARREST</u> b <u>RESPIRATORY FAILURE</u> c <u>NON SMALL CELL LUNG CANCER</u> d PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I								Approximate Interval Between Onset and Death	
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						29c MEDICAL LICENSE NO. 01044748		29d DATE SIGNED (Month Day, Year) 07/21/01	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) SERGE DRUDKIN M.D. 3229 BROADWAY STE 205 GARY, IN 46409									
31 HEALTH OFFICER'S SIGNATURE PETER BENJAMIN							32 DATE FILED (Month Day, Year) OCT 05 2000		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined			34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)		
34a PLACE OF INJURY—At home farm street factory office building etc (Specify)				34d LOCATION (Street Number or Rural Route Number, City or Town, State) 0-3-2002					
34g DATE PRONOUNCED DEAD (Month Day, Year)			34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify						



PETER BENJAMIN LAKE COUNTY AUDITOR

9.00 CS

unit #25
key #44-206-24
Gary hand Co's 5th Sub lot 26 Block 12