

Re-sub

3cc

Hold MTC

* 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. 00-0216

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER 16 CFR 163.11

2002-04-2036

2002 MAY -3 3:06

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) **John Sidney Ervin Jr.** 2 SEX **Male** 3a TIME OF DEATH **1:28 P M** 3b DATE OF DEATH (Month, Day, Yr) **March 19, 2000**

4 SOCIAL SECURITY NUMBER **303-62-7849** 5a AGE—Last Birthday (Years) **46** 5b UNDER 1 YEAR Months Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Mo, Day, Yr) **December 5, 1953** 7 BIRTHPLACE (City and State or Foreign Country) **Gary, Indiana**

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 Nursing Home Other (Specify) **Residence**

9b FACILITY NAME (If not institution, give street and number) **1237 Aetna Street** 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) **Rene' Marcus** 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Thermo Coupler** 12b KIND OF BUSINESS/INDUSTRY **U S X Steel Corp.**

13a RESIDENCE—STATE **Indiana** 13b COUNTY **Lake** 13c CITY, TOWN, OR LOCATION **Gary** 13d STREET AND NUMBER **1237 Aetna Street**

13e ZIP CODE **46403** 13f INSIDE CITY LIMITS No Yes 13g ON A FARM? No Yes 14 CITIZEN OF WHAT COUNTRY? **U S A** 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) **12th**

18 FATHER'S NAME (First, Middle, Last) **John S. Ervin Sr.** 19 MOTHER'S NAME (First, Middle, Maiden Surname) **Ercell Scott**

20a INFORMANT'S NAME (Type/Print) **Rene' Ervin** 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1237 Aetna Street Gary, Indiana 46403** 20c Relationship **Wife**

21a METHOD OF DISPOSITION Burial Entombment Cremation Removal from State Donation Other (Specify) 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **March 25, 2000 Evergreen Cemetery** 21c LOCATION—City or Town, State **Hobart, Indiana**

22a EMBALMER'S NAME **Rosenwald D. Allen Jr.** 22b EMBALMER'S LICENSE NO. **#29400047** 23 WAS DEATH REPORTED TO CORONER? No Yes

24a SIGNATURE OF FUNERAL DIRECTOR *[Signature]* 24b LICENSE NUMBER (of Licensee) **#08700298** 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404**

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) **Extensive skull fracture and laceration of brain** Approximate Interval Between Onset and Death **Unknown**

a **Due to (OR AS A CONSEQUENCE OF) gunshot wound**

b **Due to (OR AS A CONSEQUENCE OF)**

c **Due to (OR AS A CONSEQUENCE OF)**

d **Due to (OR AS A CONSEQUENCE OF)**

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 WAS AN AUTOPSY PERFORMED? (Yes or no) **YES** 28b WERE AUTOPSY FINDINGS COMPLETE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) **YES**

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 *[Signature]* 29c MEDICAL LICENSE NO **N/A** 29d DATE SIGNED (Month, Day, Year) **May 16, 2000**

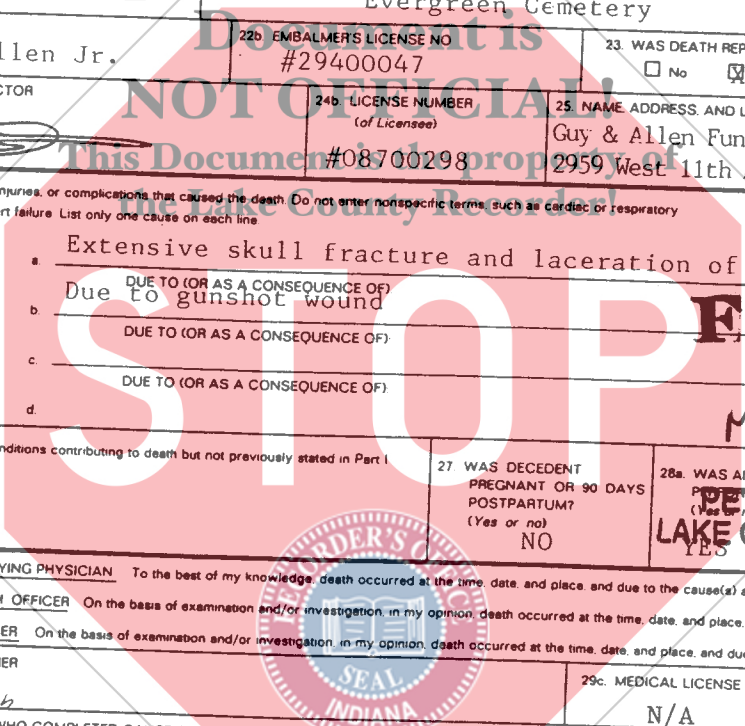
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307**

31 HEALTH OFFICER'S SIGNATURE *[Signature]* 32 DATE FILED (Month, Day, Year) **MAY 17 2000**

33 MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide 34a DATE OF INJURY (Month, Day, Year) **March 19, 2000** 34b TIME OF INJURY **Unknown** 34c INJURY AT WORK? (Yes or no) **NO** 34d DESCRIBE HOW INJURY OCCURRED **Gunshot wound**

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) **Residence** 34f LOCATION (Street and Number or Rural Route Number, City or Town, State) **1237 Aetna Street Gary, Indiana**

34g DATE PRONOUNCED DEAD (Month, Day, Year) **March 19, 2000** 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. **NO**



FILED

MAY 03 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

[Handwritten initials]
cash