TTENTION ESTATE: The Social Security # is ng requested by this state agency in order to sue its statutory responsibility. Disclosure is untary and there will be no penalty for refusal.

cal No. 92

11CC #4132-7

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE A COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Sta Date Issued FEB. 8, 2001 Franklin D. Brenneda M Hammond Health Commissione

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

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CEDENT

RENTS

ORMANT

SPOSITION

USE OF ATH

RTIFIER

ALTH FICER

1 DECEASED—NAME (First, Middle, Last)		2. SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
Fred	Bragg	Male	6:05 P M	January 27,2001

4. *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
430-14-7522	2002 042062		2047	June 21,1920	Arkansas

8a WAS DECEDENT A U S VETERAN?	8b YEAR LAST SERVED IN U S ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No	N/A	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Margaret Hospital 5454 Hohman Avenue	Hammond	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Lois D. Cleveland	Tractor Operator	U S Steel Corp.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	1540 Delaware Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT S EDUCATION (Specify only highest grade completed)	
46407	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	Black	Elementary/Secondary (0-12)	College (1-4 or 5+)

18 FATHER S NAME (First, Middle, Last)	19 MOTHER S NAME (First, Middle, Maiden Surname)
Wilson Bragg	Rosie (Unknown)

20a INFORMANT S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Lois D. Bragg	1540 Delaware Street Gary, Indiana 46407	Wife

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	February 3,2001 Fern Oak Cemetery	Griffith, Indiana

22a EMBALMER S NAME	22b EMBALMER S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Roosevelt Allen Jr.	#01051701	[ ] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	#08700646	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 nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a Respiratory Failure	12 hrs
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b DUE TO (OR AS A CONSEQUENCE OF)	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d	

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER MAY 6 2002 PETER BENJAMIN LAKE COUNTY AUDITOR

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)	28a WAS AN AUTOPSY PERFORMED?	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	NO

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
[signature]	29342	2/2/01 (February)

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. H. Dalal 5825 Broadway Merrillville, Indiana 46410

31 HEALTH OFFICER S SIGNATURE Franklin D. Brenneda M.D.

32 DATE FILED (Month, Day, Year) February 8, 2001

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)
	46313

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

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1