10CC + 3 Free VETS

* **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.

Local No. 00 0171

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

RECEIVED

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Sylvester W. Thompson

2 SEX: Male

3a TIME OF DEATH: 3:20 P.M.

3b DATE OF DEATH (Month, Day, Yr): November 29, 2000

4 *SOCIAL SECURITY NUMBER: 303-24-6773

5a AGE—Last Birthday (Years): 76

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo, Day, Yr): February 13, 1924

7 BIRTHPLACE (City and State or Foreign Country): Sapulpa, Oklahoma

8a WAS DECEDENT A U.S. VETERAN?: YES

8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient XXX ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ 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): Elsie B. Bell

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Foreman

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: 1993 Pennsylvania Street

13e ZIP CODE: 46407

13f INSIDE CITY LIMITS: ☐ No XX Yes

13g ON A FARM?: XX No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: U S A

15 WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Sylvester Thompson

19 MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Hollier

INFORMANT

20a INFORMANT'S NAME (Type/Print): Elsie B. Thompson

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1993 Pennsylvania Street Gary, Indiana 46407

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: XXXX Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): December 4, 2000 Oak Hill Cemetery

21c LOCATION—City or Town, State: Gary, Indiana

22a EMBALMER'S NAME: Rosenwald D. Allen Jr.

22b EMBALMER'S LICENSE NO: #29400047

23 WAS DEATH REPORTED TO CORONER?: XXX 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

CAUSE OF DEATH

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. Acute Myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF)

b. Coronary artery disease

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

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: COPD, Ventricular arrhythmia

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):

CERTIFIER

29a CERTIFIER (Check only one): XXX 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: 01035471

29d DATE SIGNED (Month, Day, Year): 12-6-00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): HARish ShAh 8000 E. 86th Pl. MeRRillville, IN. 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]

32 DATE FILED (Month, Day, Year): DEC 08 2000

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?

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.

2002 MAY 10 PM 3:28

LAKE COUNTY AUDITOR

RECEIVED

FILED

MAY 10 2002

006975

9.00 pd CS