

\* 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. 01 0417

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) Guyzella L. Harvey		2. SEX Female	3a. TIME OF DEATH 1:42 P M	3b. DATE OF DEATH (Month, Day, Yr) June 1, 2001
4. *SOCIAL SECURITY NUMBER 424-26-3853	5a. AGE—Last Birthday (Years) 77	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) September 18, 1923
7. BIRTHPLACE (City and State or Foreign Country) Florence, Alabama				
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 <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) Henry Harvey	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cashier		12b. KIND OF BUSINESS/INDUSTRY Food Seller
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 2653 Massachusetts Street	
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U S A	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> 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) 12th College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) Thomas Cater		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Hardin		20a. INFORMANT'S NAME (Type/Print) Henry Harvey		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2653 Massachusetts Street, Gary, Indiana 46407		20c. Relationship Husband		
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) June 6, 2001 Evergreen Cemetery		21c. LOCATION—City or Town, State Hobart, Indiana
22a. EMBALMER'S NAME Patrician Owens		22b. EMBALMER'S LICENSE NO. #08700298	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Carmelita Berry</i>		24b. LICENSE NUMBER (of Licensee) #29700070	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 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) a. <i>Congestive heart failure</i> b. <i>Arteriosclerotic heart disease</i> c. <i>Cerebrovascular Accident</i> d. <i>Hypertension</i> 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) 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 <i>Raffy Hovanessian MD</i>		29c. MEDICAL LICENSE NO. 01023183	29d. DATE SIGNED (Month, Day, Year) 7/3/2001	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Raffy Hovanessian 7863 Broadway Merrillville, IN 46410				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) JUL 06 2001
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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.		34i. MOTOR VEHICLE IDENTIFICATION NO. 000495		

PETER BENJAMIN LAKE COUNTY AUDITOR

Handwritten notes and signatures at the bottom right of the page.