* **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.

6CC

INDIANA STATE DEPARTMENT OF HEALTH

Key #42-19-20

Local No. 95-08527

CERTIFICATE OF DEATH

State No. ....

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): Gail L. Sanders
2. SEX: Female
3a. TIME OF DEATH: 1:15 p M
3b. DATE OF DEATH (Month, Day, Yr): November 14, 1995
4. *SOCIAL SECURITY NUMBER: 309-42-7241
5a. AGE—Last Birthday (Years): 56
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): October 3, 1939
7. BIRTHPLACE (City and State or Foreign Country): Pittsburgh, Pennsylvania
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 XXXXX Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 952 Ralston Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Nursing
12b. KIND OF BUSINESS/INDUSTRY: Nursing Service
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 952 Ralston Street
13e. ZIP CODE: 46406
13f. INSIDE CITY LIMITS: ☐ No XXX Yes
13g. ON A FARM?: XXX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): XXXX No ☐ Yes
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+)

PARENTS

18. FATHER'S NAME (First, Middle, Last): James W. Chester
19. MOTHER'S NAME (First, Middle, Maiden Surname): Emma McClellan

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Donna Sanders
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 952 Ralston Street Gary, Indiana 46406
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: XXXX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Evergreen Cemetery November 20, 1995
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO.: #01051696
23. WAS DEATH REPORTED TO CORONER?: XXX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): #08700646
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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Carcinoma of lung with extensive metastasis to bones lung liver — Approximate Interval Between Onset and Death: 1 1/2 yr.

DUE TO (OR AS A CONSEQUENCE OF)

b.

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: S/P chemotherapy cachexia Respiratory Failure

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):
XX 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] MD
29c. MEDICAL LICENSE NO.: 01035695
29d. DATE SIGNED (Month, Day, Year): 11/29/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Sanghvi M.D. 8127 Merrillville Rd. Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): DEC 01 1995

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
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.

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

FILED FOR RECORD
2002 062750
2002 JUL 11 PM 2:15
MORRIS W. CARTER
RECORDER
FILED
JUL 11 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR
Document is NOT OFFICIAL!
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STOP