C. I

No. 91-0130

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

Robert L. Lewis
2148 W. 11th Ave
Gary, In. 46404

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last): Sadie August
2. SEX: Female
3a. TIME OF DEATH: 01:16AM
3b. DATE OF DEATH (Month, Day, Yr.): February 10, 1991
4. SOCIAL SECURITY NUMBER: 345-09-3997
5a. AGE—Last Birthday (Years): 88
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo, Day, Yr): MAR 17, 1902
7. BIRTHPLACE (City and State or Foreign Country): Monroe, Louisiana

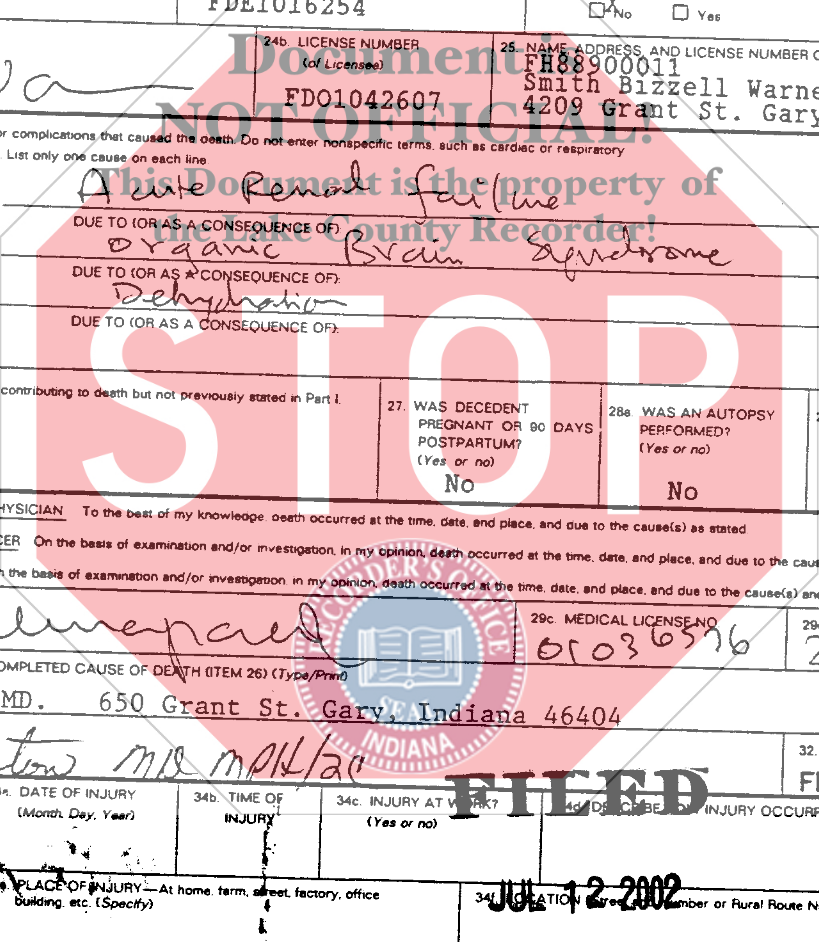
2002 063944

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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

2002 JUL 17 AM 8:58

MORRIS CARTER RECORDER

9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
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): Melvin August Sr.
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2073 Monroe Lane
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Afro Am
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):
18. FATHER'S NAME (First, Middle, Last): Hezekiah Young
19. MOTHER'S NAME (First, Middle, Maiden Surname): Matilda Unavailable
20a. INFORMANT'S NAME (Type/Print): Melvin August Sr.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2073 Monroe Lane, Gary, Indiana 46407
20c. Relationship: Husband
21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEB 14, 1991 Oakhill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana 46408
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01042607
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell Warner & Son 4209 Grant St. Gary, In. 46408



Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!
STOP
RECORDER'S OFFICE SEAL INDIANA

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. Acute Renal failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Organic Brain Syndrome
DUE TO (OR AS A CONSEQUENCE OF):
c. Dehydration
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

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) 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: K. Umapathy
29c. MEDICAL LICENSE NO.: 0103 6596
29d. DATE SIGNED (Month, Day, Year): 2-15-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. K. A. Umapathy MD. 650 Grant St. Gary, Indiana 46404
31. HEALTH OFFICER'S SIGNATURE: Kelara E. Foster MD MPH/ac
32. DATE FILED (Month, Day, Year): FEB. 19 1991

FILED

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)

JUL 12 2002

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

PETER BENJAMIN
LAKE COUNTY AUDITOR

000913 9.50

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

8911