Key # 47-164-20

2CC

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. 02 0500

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2002 APR 17 AM 10:09
MORRIS W. CARTER
RECORDER

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Daisy Dell Banks

2 SEX: Female

3a TIME OF DEATH: 9:20 PM

3b DATE OF DEATH (Month, Day, Yr.): August 2, 2002

4 *SOCIAL SECURITY NUMBER: 414-34-4249

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.): November 12, 1925

7 BIRTHPLACE (City and State or Foreign Country): Tutwiller, Mississippi

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: XX Inpatient; ER/Outpatient; DOA; DOR; Nursing Home; Residence; Other (Specify)

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): Doc C. Banks

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

12b KIND OF BUSINESS/INDUSTRY: Gary Community School

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 1835 Chase Street

13e ZIP CODE: 46404

13f INSIDE CITY LIMITS: XX Yes

13g ON A FARM? XX No

14 CITIZEN OF WHAT COUNTRY? U S A

15 WAS DECEDENT OF HISPANIC ORIGIN? XX No (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+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Cammie S. Stranton

19 MOTHER'S NAME (First, Middle, Maiden Surname): Lula Washington

INFORMANT

20a INFORMANT'S NAME (Type/Print): Doc C. Banks

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1835 Chase Street Gary, Indiana 46404

20c Relationship: Husband

DISPOSITION

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

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 8, 2002 Evergreen Cemetery

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

22a EMBALMER'S NAME: Roosevelt Allen Jr.

22b EMBALMER'S LICENSE NO.: #01051701

23 WAS DEATH REPORTED TO CORONER? XX Yes

24a SIGNATURE OF FUNERAL DIRECTOR

24b LICENSE NUMBER (of Licensee): #08700298

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704

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. marked cachexia
DUE TO (OR AS A CONSEQUENCE OF):
b. malignant metastatic tumor
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

Approximate Interval Between Onset and Death

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: mal Nutrition

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):
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): 8/8/02

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 200 E. 86th Place Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE

32 DATE FILED (Month, Day, Year): AUG 12 2002

FILED
APR 17 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

33 MANNER OF DEATH: XX 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)

001245

34g DATE PRONOUNCED DEAD (Month, Day, Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.