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Key # 45-377-32

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 511

Apr 14 1998 Date Issued
Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED - NAME (First Middle Last) Percy L. Brown		2 SEX Male	3a TIME OF DEATH 9:35 a.m.	3b DATE OF DEATH (Month Day Yr) June 9, 1990
4 SOCIAL SECURITY NUMBER 416 18 5353	5a AGE - Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) May 25, 1920
7 BIRTHPLACE (City and State or Foreign Country) Montgomery, Ala.	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) St. Margaret's Hospital		9c CITY, TOWN, OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Willie Mae Smiley	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker	12b KIND OF BUSINESS/INDUSTRY J.L. Steel Corp.	
13a RESIDENCE - STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 1426 W. 18th Ave.	
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican, etc)	16 RACE - American Indian, Black, White, etc (Specify) Black
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) Thomas Brown		
19 MOTHER'S NAME (First Middle Maiden Surname) Viola Cole		20a INFORMANT'S NAME (Type, Print) Willie Mae Brown		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1426 W. 18th Ave. Gary, In. 46407		20c Relationship Wife		
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 15, 1990 Evergreen Cemetery		21c LOCATION - City or Town, State Hobart, India
22a EMBALMER'S NAME Roosevelt Allen Jr.		22b EMBALMER'S LICENSE NO. 01051701		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie</i>		24b LICENSE NUMBER (of License) 08700646		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, 2959 W. 11th Ave. Gary, In 46404
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 Cardiomyopathy failure DUE TO (OR AS A CONSEQUENCE OF) b Septicemia DUE TO (OR AS A CONSEQUENCE OF) c GRANDIOS DUE TO (OR AS A CONSEQUENCE OF) d				
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) <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>J. Cahon</i>			29c MEDICAL LICENSE NO. 35923	29d DATE SIGNED (Month Day Year) June 10, 1990
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) J. Cahon, M.D. 7005 Calumet Avenue, Muncie, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Granholm J. Jernandez</i>				32 DATE FILED (Month Day Year) JUN 11 1990
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no) JUL 16 2003
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY - At home, farm, street, factory, building etc (Specify) STEPHEN R. STIGLICH LAKE COUNTY AUDITOR		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc 9.00 LP Cash		

DECEDENT

PARENTS

INFORMANT

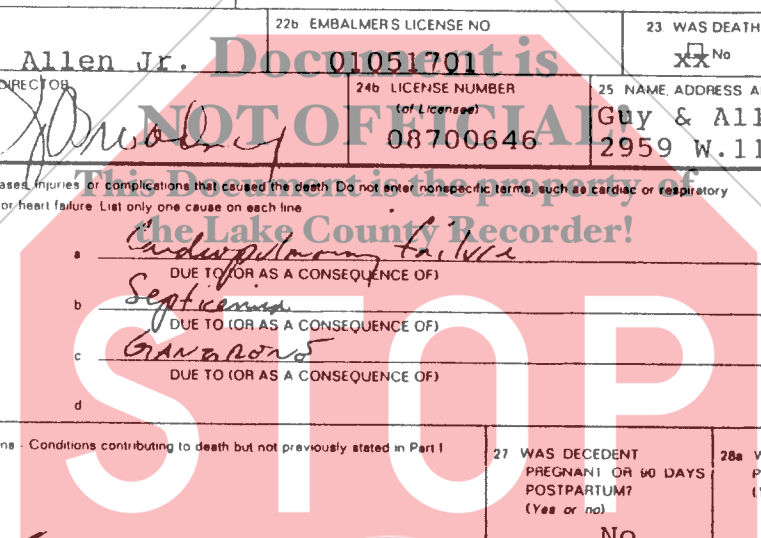
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



2003 JUN 16 AM 11:00
FILED FOR RECORD
LAKE COUNTY INDIANA