

INDIANA STATE DEPARTMENT OF HEALTH

ORIGINAL

* 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. 01 0817

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) Berneice Jones		2 SEX Female		3a TIME OF DEATH 11:58 p.m.		3b DATE OF DEATH (Month, Day, Yr.) November 25, 2001	
4 *SOCIAL SECURITY NUMBER 308-32-2932		5a AGE—Last Birthday (Years) 89		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr.) January 6, 1912		7 BIRTHPLACE (City and State or Foreign Country) Shaw, 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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 2101 Taft 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) Housekeeper		12b KIND OF BUSINESS/INDUSTRY Hospital	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Gary		13d STREET AND NUMBER 2101 Taft Street	
13e ZIP CODE 46404		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input 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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) Shep Byrd III			
19 MOTHER'S NAME (First, Middle, Maiden (Married)) Alberta Dunn		20a INFORMANT'S NAME (Type/Print) Jacqueline D. Jones				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 Taft Street Gary, Indiana 46404	
20c Relationship Daughter		21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <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) November 29, 2001 Fern Oak Cemetery		21c LOCATION—City or Town, State Griffith, Indiana	
22a EMBALMER'S NAME Patrician Owens		22b EMBALMER'S LICENSE NO. #08700298		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Broderick</i>		24b LICENSE NUMBER (of Licensee) #08700646		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Director, Inc. 2959 West 11th Avenue Gary, Indiana 46404 83007704			
26 PART I Enter the disease, 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>Coronary Artery Disease</i> b <i>Myocardial Infarction</i> c 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)			
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>William E. Washington, M.D.</i>						29c MEDICAL LICENSE NO. 01630968	
29d DATE SIGNED (Month, Day, Year) 12-21-01						30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) William E. Washington, M.D. 5041 Broadway Gary In 46409	
31 HEALTH OFFICER'S SIGNATURE <i>William E. Washington, M.D.</i>						32 DATE FILED (Month, Day, Year) DEC 17 2001	
33 MANNER OF DEATH <input checked="" 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)	
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) 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. 001967					

DECEDENT

PARENTS

INFORMANT

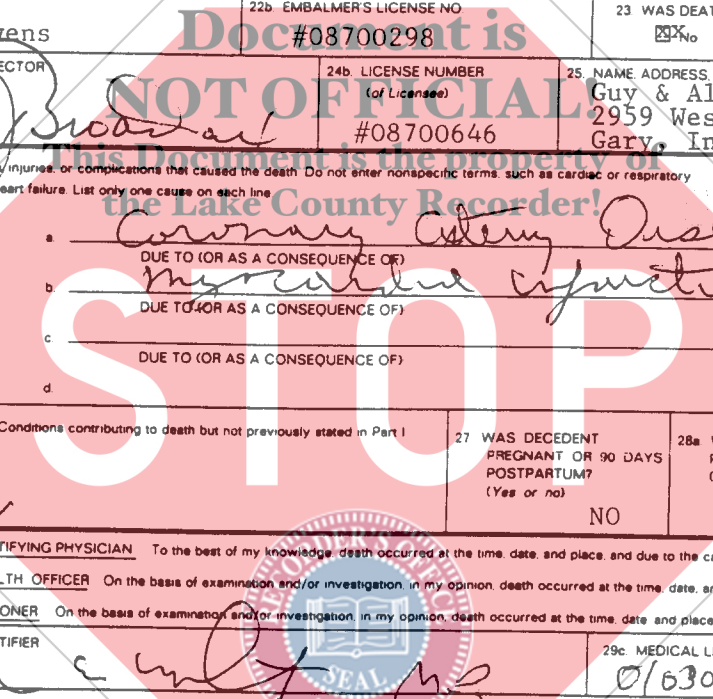
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

ref. key # 47-421-1



FILED JUL 28 2003

Handwritten initials and numbers: 9, 36, MTC