5CC

* 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.

INDIANA STATE DEPARTMENT OF HEALTH

#47-57-14

CERTIFICATE OF DEATH

Local No. 00 0264

State No. #42-128-17

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): Willie B. Howell
2 SEX: Male
3a TIME OF DEATH: 6:18 A M
3b DATE OF DEATH (Month, Day, Yr): April 10, 2000
4 *SOCIAL SECURITY NUMBER: 425-14-3233
5a AGE—Last Birthday (Years): 85
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo, Day, Yr): November 12, 1914
7 BIRTHPLACE (City and State or Foreign Country): Aberdeen, 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 ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ 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): Kathleen Smith
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance
12b KIND OF BUSINESS/INDUSTRY: USS Lead Refinery
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Gary
13d STREET AND NUMBER: 1300 Ellsworth Street
13e ZIP CODE: 46404
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: U S A
15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): 8th; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): James Howell
19 MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Jones

INFORMANT

20a INFORMANT'S NAME (Type/Print): Kathleen Howell
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1300 Ellsworth Street Gary, Indiana 46404
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 15, 2000 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?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Carmel A. Wiley
24b LICENSE NUMBER (of Licensee): #29700070
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

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Congestive cardiac failure	
DUE TO (OR AS A CONSEQUENCE OF) b	arteriosclerotic heart disease	
DUE TO (OR AS A CONSEQUENCE OF) c	Generalized arteriosclerosis	
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: Bronchial asthma, Uncontrolled Diabetes
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)
☒ 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]
29c MEDICAL LICENSE NO: IN25043
29d DATE SIGNED (Month, Day, Year): 4/13/2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): KRISHNAN ... TIMMAN, 8300 BROADWAY, Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD, MPH
32 DATE FILED (Month, Day, Year): APR 17 2000

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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)
34g DATE PRONOUNCED DEAD (Month, Day, Year)
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

FILED 000555 OCT 6 2003 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

900 SS CS