6cc
3vets

Local No. 93 0167

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Henderson Townsend	2. SEX: Male	3a. TIME OF DEATH: 1:25 P.M.	3b. DATE OF DEATH (Month, Day, Yr.): March 4, 1993
4. SOCIAL SECURITY NUMBER: 426-16-2881	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.): January 23,1917
7. BIRTHPLACE (City and State or Foreign Country): Natchez,Mississippi	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
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: Married	11. SURVIVING SPOUSE (If wife, give maiden name): Mamie Jackson	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Laborer	12b. KIND OF BUSINESS/INDUSTRY: USX Steel Corp.
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Gary	13d. STREET AND NUMBER: 1309 Van Buren Street
13e. ZIP CODE: 46407	13f. INSIDE CITY LIMITS ☐ No ☒ Yes; 13g. ON A FARM? XX ☐ 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): 4th; College (1-4 or 5+):		

PARENTS

18. FATHER'S NAME (First, Middle, Last): Timothy Townsend	19. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Cummings

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mamie Townsend	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 Van Buren ST. Gary,Indiana 46407	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Entombment ☒ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 9, 1993 Local	21c. LOCATION—City or Town, State: Natchez,Mississippi
22a. EMBALMER'S NAME: Roosevelt Allen Sr.	22b. EMBALMER'S LICENSE NO: #01051696	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): 08700298	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 83007704 Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary,Indiana 46404

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. Aspiration	25 min
	DUE TO (OR AS A CONSEQUENCE OF): b. pneumonitis	5 days
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Multiple Myeloma

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: 29392	29d. DATE SIGNED (Month, Day, Year): 3/12/93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Dalal 3229 Broadway Gary, IN 46408

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]	32. DATE FILED (Month, Day, Year): MAR 1 9 1993

CORONER USE ONLY

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
OCT 8 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

000743 400 6401

2003 OCT -8 PM 3:00
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
MORRIS W. CARTER RECORDER

2003 083083

SDH06-004 State Form 10110 (R/1-92) DEATHCERT.PD 1

→ John Henry Hall → 1937 Madison St. PO Box 1448 Gary, IN 46407