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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to sue its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

Local No. 1149-03

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

RELATIVES

INFORMANT

POSITION

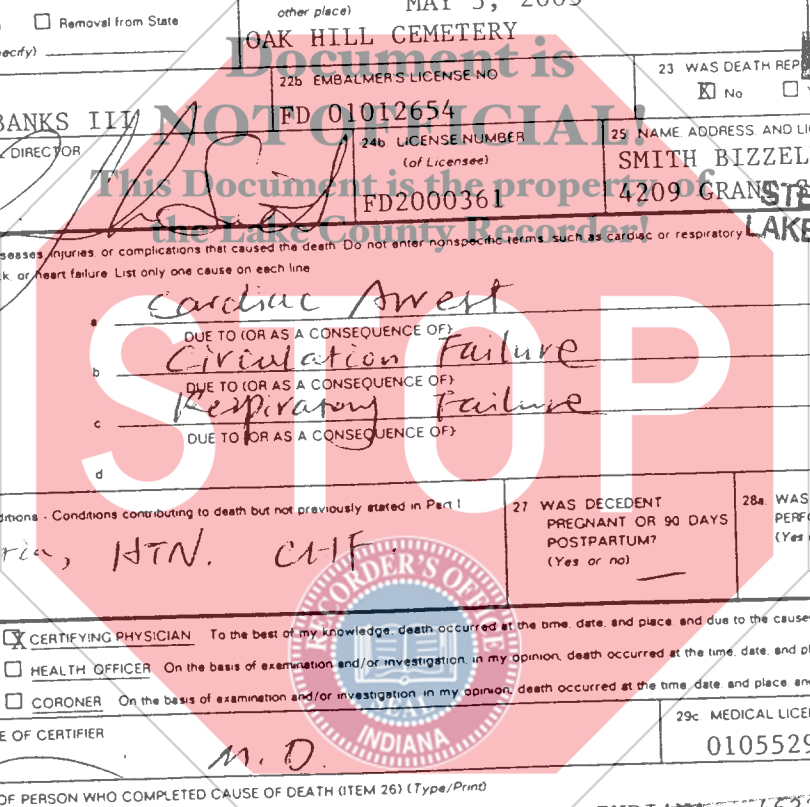
USE OF

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>MELVINA E. BROOKS</b>		2 SEX <b>FEMALE</b>	3a TIME OF DEATH <b>5:30 A.M.</b>	3b DATE OF DEATH (Month Day Year) <b>APRIL 27, 2003</b>
4 *SOCIAL SECURITY NUMBER <b>411-36-5520</b>	5a AGE—Last Birthday (Years) <b>84</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>JANUARY 01, 1919</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>EXCELSIOR, WEST VIRGINIA</b>				
9a PLACE OF DEATH (Check only one. See instructions)				
8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	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) <b>THE COMMUNITY HOSPITAL</b>			9c CITY, TOWN OR LOCATION OF DEATH <b>MUNSTER</b>	9d COUNTY OF DEATH <b>LAKE</b>
10 MARITAL STATUS (Specify) <b>WIDOWED</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOUSE CLEANER</b>		12b KIND OF BUSINESS/INDUSTRY <b>SELF EMPLOYED</b>
13a RESIDENCE—STATE <b>INDIANA</b>		13b COUNTY <b>LAKE</b>	13c CITY, TOWN OR LOCATION <b>HAMMOND</b>	
13d STREET AND NUMBER <b>6811 KENNEDY AVENUE</b>				
13e ZIP CODE <b>46323</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>BLACK</b>
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>CASSIE BELL (UNAVAILABLE)</b>		
18 FATHER'S NAME (First Middle Last) <b>SAMUEL WALKER</b>			20a MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6811 KENNEDY AVENUE HAMMOND, INDIANA 46323</b>	20c Relationship <b>GRANDDAUGHTER</b>
21a METHOD OF DISPOSITION <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) <b>MAY 3, 2003 OAK HILL CEMETERY</b>		21c LOCATION—City or Town, State <b>GARY, INDIANA</b>
22a EMBALMER'S NAME <b>SHERMAN G. BANKS III</b>		22b EMBALMER'S LICENSE NO. <b>FD 01012654</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) <b>FD2000361</b>	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>SMITH BIZZELL &amp; WARNER FUNERAL HOME 4209 GRAND STREET, GARY, IN 46408 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR</b>	
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) <b>Cardiac Arrest</b>				
a DUE TO (OR AS A CONSEQUENCE OF) <b>Circulation Failure</b>				
b DUE TO (OR AS A CONSEQUENCE OF) <b>Respiratory Failure</b>				
c DUE TO (OR AS A CONSEQUENCE OF)				
d DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I <b>Dementia, HTN, CHF</b>				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a WAS AN AUTOPSY PERFORMED? (Yes or 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		29c MEDICAL LICENSE NO. <b>01055296</b>	29d DATE SIGNED (Month Day Year) <b>APRIL 28, 2003</b>	
29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>XIAO LI, M.D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321</b>		
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				
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)
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.		

Melvina Edmond  
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FILED  
OCT 29 2003

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