ccc Re-sub

Key # 43-180-3

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 93-0250

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Bessie L. Milligan

2 SEX: Female

3a TIME OF DEATH: 2:35 A M

3b DATE OF DEATH (Month, Day, Yr): March 24, 1993

4 SOCIAL SECURITY NUMBER: 255-38-2742

5a AGE—Last Birthday (Years): 67

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo. Day. Yr): October 29, 1925

7 BIRTHPLACE (City and State or Foreign Country): Macon, Georgia

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 ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution, give street and number): 4124 West 10th Avenue

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): Robert Milligan

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker

12b KIND OF BUSINESS/INDUSTRY: Home

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Gary

13d STREET AND NUMBER: 4124 West 10th Avenue

13e ZIP CODE: 46406

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): 8; College (1-4 or 5+): 3 Years

PARENTS

18 FATHER'S NAME (First, Middle, Last): Roosevelt Franklin

19 MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Bowen

INFORMANT

20a INFORMANT'S NAME (Type/Print): Robert Milligan

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4124 W. 10th Avenue Gary, Indiana 46406

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 29, 1993 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? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): #08700646

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 W. 11[illegible] 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions if any which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death

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)

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: David Ross M.D.

29c MEDICAL LICENSE NO.: 01018989

29d DATE SIGNED (Month, Day, Year): 3/30/93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. David Ross 1619 West 5th Avenue Gary Indiana 46404

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]

32 DATE FILED (Month, Day, Year): JUN 07 1993

CORONER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

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.

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

Vernetta West 4124 W. 10th Ave Gary, IN 46404

900 Rev Cash