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Key # 47-399-2

* 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

CERTIFICATE OF DEATH

Local No. 99-0421 State No.

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): John Lee Luellen
2. SEX: Male
3a. TIME OF DEATH: 9:28PM M
3b. DATE OF DEATH (Month, Day, Yr.): June 14, 1999
4. *SOCIAL SECURITY NUMBER: 408-42-9591
5a. AGE--Last Birthday (Years): 69
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): February 15, 1930
7. BIRTHPLACE (City and State or Foreign Country): LaMarr, 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: X Inpatient / ER/Outpatient / DOA; OTHER: Nursing Home / Residence / Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Gary Methodist 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): Ernestine Johnson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Furnace Operator
12b. KIND OF BUSINESS/INDUSTRY: U.S Steel Mill
13a. RESIDENCE--STATE: Indiana 46404
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2480 Noble Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: No / X Yes
13g. ON A FARM?: X No / Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: X 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): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Cuellen Lueallen
19. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Roger

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ernestine Luellen
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2480 Noble Street Gary, Indiana 46404
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: X Burial / Cremation / Donation / Entombment / Removal from State / Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 19, 1999 Calumet Park Cemetery
21c. LOCATION--City or Town, State: Merrillville, IN
22a. EMBALMER'S NAME: Sherman Banks III
22b. EMBALMER'S LICENSE NO.: FDO 1016254
23. WAS DEATH REPORTED TO CORONER?: No / Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Sherman Banks
24b. LICENSE NUMBER (of Licensee): FDO 1016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034, 4209 Grant St, Gary, IN, 46408

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CAUSE OF DEATH

28. 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. Multiple Organ Failure
DUE TO (OR AS A CONSEQUENCE OF):
b.
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

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):
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): 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] Cannon MD
29c. MEDICAL LICENSE NO.: 01037499
29d. DATE SIGNED (Month, Day, Year): 6/21/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Cannon 1619 West 5th Avenue 886-4788

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD MPH
32. DATE FILED (Month, Day, Year): JUN 24 1999

FILED APR 22 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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.

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CASH

SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1