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* **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. 04 0157 State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): William T. Gibson
2. SEX: Male
3a. TIME OF DEATH: 7:00 A M
3b. DATE OF DEATH (Month, Day, Yr.): March 8, 2004
4. *SOCIAL SECURITY NUMBER: 312-34-3440
5a. AGE—Last Birthday (Years): 68
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): April 9, 1935
7. BIRTHPLACE (City and State or Foreign Country): Tunica, 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 XXXX 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 (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Janet Epperson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Police Officer
12b. KIND OF BUSINESS/INDUSTRY: Gary Police Departmen
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 8401 Hickory Avenue
13e. ZIP CODE: 46403
13f. INSIDE CITY LIMITS: No XXYes
13g. ON A FARM? XXNo Yes
14. CITIZEN OF WHAT COUNTRY? U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? XXNo 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); College (1-4 or 5+): 5+

PARENTS

18. FATHER'S NAME (First, Middle, Last): George Gibson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanora Morgan

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Janet Gibson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8401 Hickory Avenue Gary, Indiana 46403
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: Burial; XXCremation; Donation; Entombment; Removal from State; Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 12, 2004 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO: #01051701
23. WAS DEATH REPORTED TO CORONER? XXNo Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Carmelita Berry
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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardio Myopathy
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: Dyslipidemia Anoxic Encephalopathy

27. WAS CASE REFERRED? (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):
XX 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: Dr. H. Shah
29c. MEDICAL LICENSE NO: 01035471
29d. DATE SIGNED (Month, Day, Year): 3-15-04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): 200 E 86th Place Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): MAR 19 2004

33. MANNER OF DEATH: XXNatural; 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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