900

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.*

Local No. 339

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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): James Rivers Taylor Sr.
2. SEX: Male
3a. TIME OF DEATH: 11:30 AM
3b. DATE OF DEATH (Month, Day, Yr.): November 14, 2003
4. *SOCIAL SECURITY NUMBER: 410-07-4784
5a. AGE - Last Birthday (Years): 89
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): August 20, 1914
7. BIRTHPLACE (City and State or Foreign Country): Obion County Tennessee
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A

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): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Ida Florence Jones
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Steam Production
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel Mill
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 1176 Polk Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: [ ] No [x] Yes
13g. ON A FARM?: [x] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 12; College (1-4 or 5+): N/A

PARENTS

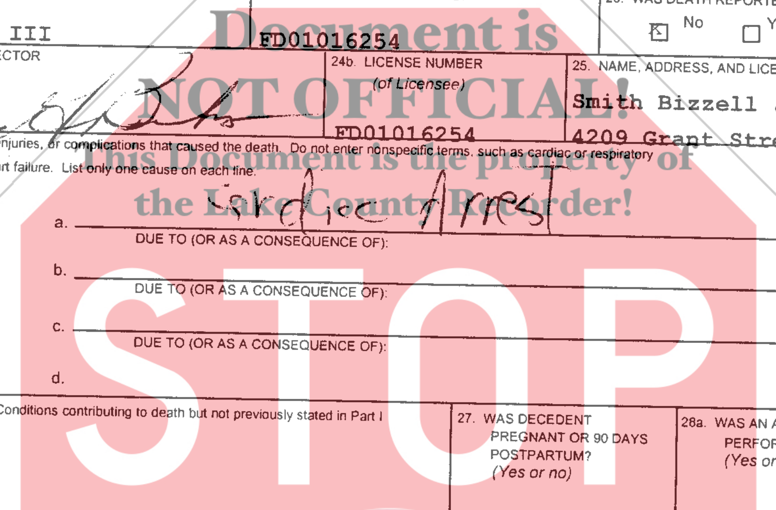
18. FATHER'S NAME (First, Middle, Last): Frank Taylor
19. MOTHER'S NAME (First, Middle, Maiden Surname): Verneda Tyes

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ida Florence Taylor
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1176 Polk Street, Gary, IN 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [x] Burial [ ] Cremation [ ] Donation [ ] Other (Specify) [ ] Entombment [ ] Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 19, 2003 EVERGREEN MEMORIAL PARK
21c. LOCATION - City or Town, State: HOBART, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD01016254
23. WAS DEATH REPORTED TO CORONER?: [x] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner FH19600034 4209 Grant Street, Gary, Indiana 46407-



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STOP

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.
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)
28a. WAS AN AUTOPSY PERFORMED? (Yes or 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] MD
29c. MEDICAL LICENSE NO.: 01030852
29d. DATE SIGNED (Month, Day, Year): 11-24-03
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Elliot Stokar 761 45th Street Suite 108 Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Timothy Raymond
32. DATE FILED (Month, Day, Year): 12/8/03

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.

2004 040140

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2004 MAY 14 ... MORRIS ... RECORDER

FILED MAY 14 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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ck# 1947

SDH06-004