

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to voluntary and there will be no penalty for refusal.

500 + 3 Free VETS
INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.

Local No. 98-0830

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (First, Middle, Last) Willie Pierce		2. SEX Male	3a. TIME OF DEATH 2:13 P M	3b. DATE OF DEATH (Month, Day, Yr.) November 26, 1998
4. #SOCIAL SECURITY NUMBER 311-40-8384	5a. AGE—Last Birthday (Years) 57	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) September 7, 1941
7. BIRTHPLACE (City and State or Foreign Country) Blythesville, Arkansas		8a. WAS DECEDENT A U.S. VETERAN? YES		
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1964		9a. PLACE OF DEATH (Check only one. See instructions.) 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) 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) Rosemarie King	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Mechanic		12b. KIND OF BUSINESS/INDUSTRY Inland Steel Corp.
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 1161 Hanley Street
13e. ZIP CODE 46406	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U S A	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) Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) Percy Conerly		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Kathleen Stinson		20a. INFORMANT'S NAME (Type/Print) Rosemarie Pierce		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1161 Hanley Street Gary, Indiana 46406		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) November 30, 1998 Evergreen Cemetery		21c. LOCATION—City or Town, State Hobart, Indiana
22a. EMBALMER'S NAME Rosenwald D. Allen Jr		22b. EMBALMER'S LICENSE NO. #29400047	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Probst</i>		24b. LICENSE NUMBER (of Licensee) #08700646	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704	
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. <u>Not coronary atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Acute bleeding stomach ulcer</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____				Approximate Interval Between Onset and Death Unknown
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) Yes		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes
29a. CERTIFIER (Check only one) <input 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 checked="" type="checkbox"/> DEPUTY 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 <i>Valerie Probst</i> Deputy		29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month, Day, Year) December 7, 1998	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Donna Melyon, Deputy-Coroner, 2293 North Main Street, Crown Point, Indiana 46307				
31. HEALTH OFFICER'S SIGNATURE <i>Donna Melyon MD MPH</i>				32. DATE FILED (Month, Day, Year) DEC 10 1998
33. MANNER OF DEATH <input checked="" 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) November 26, 1998		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				