6

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

Local No. 03-0371

CERTIFICATE OF DEATH

State No. Ky # 47-20-22

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): Wesley R. Avery
2. SEX: Male
3a. TIME OF DEATH: 10:05 A M
3b. DATE OF DEATH (Month, Day, Yr.): May 23, 2003
4. SOCIAL SECURITY NUMBER: 411-30-8189
5a. AGE--Last Birthday (Years): 77
5b. UNDER 1 YEAR Months / Days
5c. UNDER 1 DAY Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): March 12, 1926
7. BIRTHPLACE (City and State or Foreign Country): Rialton, Tennessee
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
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): 420 East 36th Avenue
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): Allie Mae Lewis
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Retired
12b. KIND OF BUSINESS/INDUSTRY:
13a. RESIDENCE--STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 420 East 36th Avenue
13e. ZIP CODE: 46409
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): 6; College (1-4 or 5+):

2003 005408

PARENTS

18. FATHER'S NAME (First, Middle, Last): Wesley Avery
19. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice Moore

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Allie Mae Avery
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 420 East 36th Avenue Gary, IN 46409
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 29, 2003 Evergreen Memorial Park
21c. LOCATION--City or Town, State: Hobart, IN
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO: FD 01016254
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee): FD 01016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034 4209 Grant St, Gary, IN, 46408

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. HYPOTENSION AND APNEA — Approximate Interval Between Onset and Death: 10 MINUTES
DUE TO (OR AS A CONSEQUENCE OF):
b. MULTIPLE MYELOMA — 20 YEARS
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): 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: MD
29c. MEDICAL LICENSE NO: 01042940
29d. DATE SIGNED (Month, Day, Year): JUNE 2, 2003

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr N. Gupta 929 Ridge Road Suite 4B Munster, IN
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): JUN 05 2003

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. [illegible] (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, [illegible] pedestrian, etc.

FILED 002577 JUN 30 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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