2cc

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 04 0626

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): Ophelia W. Holliday
2. SEX: Female
3a. TIME OF DEATH: 11:22 PM
3b. DATE OF DEATH (Month, Day, Yr.): October 14, 2004
4. *SOCIAL SECURITY NUMBER: 309-14-9624
5a. AGE - Last Birthday (Years): 90
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo., Day, Yr.): September 23, 1914
7. BIRTHPLACE (City and State or Foreign Country): Waverly Alabama
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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify); ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1055 Tyler Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name):
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Matron
12b. KIND OF BUSINESS/INDUSTRY: RR Donnelly & Son
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 1055 Tyler Street
13e. ZIP CODE: 46402
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 8; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): George Webb
19. MOTHER'S NAME (First, Middle, Maiden Surname): Eula Hart

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Eva Gillespi
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1560 Wallace Street, Gary, IN 46404
20c. Relationship: Niece

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 19, 2004 Oak Hill CEMETERY
21c. LOCATION - City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD01016254
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR
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-

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. FAILURE TO THRIVE
DUE TO (OR AS A CONSEQUENCE OF)
b. CHF
DUE TO (OR AS A CONSEQUENCE OF)
c. CRI
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): NO
28. WAS AUTOPSY PERFORMED?: NO
29. 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
29c. MEDICAL LICENSE NO: 02002106
29d. DATE SIGNED (Month, Day, Year): 10/19/04

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. Rupesh J. Shah 202 E. 86th Pl. Merrillville IN 46410
31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): OCT 26 2004

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.

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