



\* 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.

5CC + 3 FREE Vets  
INDIANA STATE DEPARTMENT OF HEALTH

Local No. 00-0937

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Everett T. Bean Jr.				2 SEX Male		3a TIME OF DEATH 8:00 A M		3b DATE OF DEATH (Month, Day, Yr) December 19, 200					
4 *SOCIAL SECURITY NUMBER 310-14-9562		5a AGE—Last Birthday (Years) 78		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) June 22, 1922		7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana			
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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
9b. FACILITY NAME (If not institution, give street and number) 518 Ellsworth Street				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) Ariminta Henderson		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Annealer				12b. KIND OF BUSINESS/INDUSTRY US Steel Sheet & Ti					
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary				13d. STREET AND NUMBER 518 Ellsworth Street					
13e. ZIP CODE 46404		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) Everett T. Bean Sr.						19. MOTHER'S NAME (First, Middle, Maiden Surname) Vera Curry							
20a. INFORMANT'S NAME (Type/Print) Ariminta Bean				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Ellsworth Street Gary, Indiana 46404				20c. Relationship Wife					
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Entombment <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) December 23, 2000 Oak Hill Cemetery				21c. LOCATION—City or Town, State Gary, Indiana					
22a. EMBALMERS NAME Rosenwald D. Allen Jr.				22b. EMBALMERS LICENSE NO. #29400047		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR 				24b. LICENSE NUMBER (of Licensee) #08700298		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>Organic Heart Disease</u> b. <u>Diabetes Insufficiency</u> c. <u>Diabetes Mellitus - insulin</u> 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)			
29a. CERTIFIER (Check only one) <input checked="" 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 type="checkbox"/> 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. 01030338		29d. DATE SIGNED (Month, Day, Year) 1-8-2001					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) Dr. Longley 8939 Broadway Merrillville, Indiana 46410													
31 HEALTH OFFICER'S SIGNATURE 						32. DATE FILED (Month, Day, Year) JAN 12 2001							
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> 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									

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

