TENTION ESTATE: The Social Security # is g requested by this state agency in order to ue its statutory responsibility. Disclosure is ntary and there will be no penalty for refusal.

Key # 45-281-40

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

cal No. 2169-04

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

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1. DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Edward	Francis	Male	12:34 A M	September 12, 2004

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
417-28-1748	80			July 12, 1924	Alabama

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
YES	1947	HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Methodist Hospital Southlake	Merrillville	Lake

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
Married	Anne L. Smith	Millwright	U S Steel Corp.

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Gary	345 Calhoun Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5 +)
46404	XX No ☐ Yes	XX No ☐ Yes	U S A	XX No ☐ Yes	Black	12th	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Willie Francis	Cora Waxton

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Annie L. Francis	345 Calhoun Street Gary, Indiana 46404	Wife

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ____ ☐ Entombment	September 18, 2004 Evergreen Cemetery	Hobart, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Rosenwald D. Allen Jr.	#29400047	XX No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Valerie J. Broadnax	#08700646	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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Kidney failure	1 month
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Heart failure

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No)	28a. WAS AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	

29. CERTIFIER (Check only one)

XXX ☐ 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.	29d. DATE SIGNED (Month, Day, Year)
M.D.	01035936	10/2/4

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. Ajam 8668 Broadway Merrillville, Indiana 46410

31. HEALTH OFFICER'S SIGNATURE Susan W Burt D.O.

32. DATE FILED (Month, Day, Year) OCT 13, 2004

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
XXX ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL ON FILE WITH THE INDIANA STATE DEPARTMENT OF HEALTH

OCT 27 2004

FILED
2004 NOV -3 PM 2:08
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
MORRIS W. CARTER RECORDER
NOV 2004
STEPHEN R. STIGLICH INC
LAKE COUNTY AUDITOR

000337 90

SDH06-004 State Form 10110 (R5/1-99)

HR-05994095