10CC

Key #46-208-38

**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.

Local No. 3208-04

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Joel H. Harris
2. SEX: Male
3a. TIME OF DEATH: 5:32 A M
3b. DATE OF DEATH (Month, Day, Yr.): December 29, 2004
4. *SOCIAL SECURITY NUMBER: 405-50-3940
5a. AGE—Last Birthday (Years): 64
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): January 12, 1940
7. BIRTHPLACE (City and State or Foreign Country): Madisonville, Kentucky
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: XX Inpatient; ☐ ER/Outpatient; ☐ DOA; OTHER: ☐ Nursing Home; ☐ Other (Specify); ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Southlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Delores Scisney
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Director of General Services
12b. KIND OF BUSINESS/INDUSTRY: City of Gary
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2737 Jefferson Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U S A
15. WAS DECEDENT OF HISPANIC ORIGIN?: XX 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): 12th; College (1-4 or 5 + ):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Doss Harris
19. MOTHER'S NAME (First, Middle, Maiden Surname): Josie Gant

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Delores Harris
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2737 Jefferson Street Gary, Indiana 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial; ☐ Cremation; ☐ Removal from State; ☐ Donation; ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 3, 2005 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO.: #01051701
23. WAS DEATH REPORTED TO CORONER?: XX ☐ 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

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. CARDIAC ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b.
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

Approximate Interval Between Onset and Death

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

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)

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.: 01047536
29d. DATE SIGNED (Month, Day, Year): 1/3/05

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 251 W 84th DRIVE, MERRILLVILLE, IN 46410 Dr, Szefler
31. HEALTH OFFICER'S SIGNATURE: Susan J Bat D.O.
32. DATE FILED (Month, Day, Year): January 10, 2005

33. MANNER OF DEATH: XX 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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JAN 10 2005

9.00 KM COSH



FILED JAN 19 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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