

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. 04 0663

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

PARENTS

INFORMANT

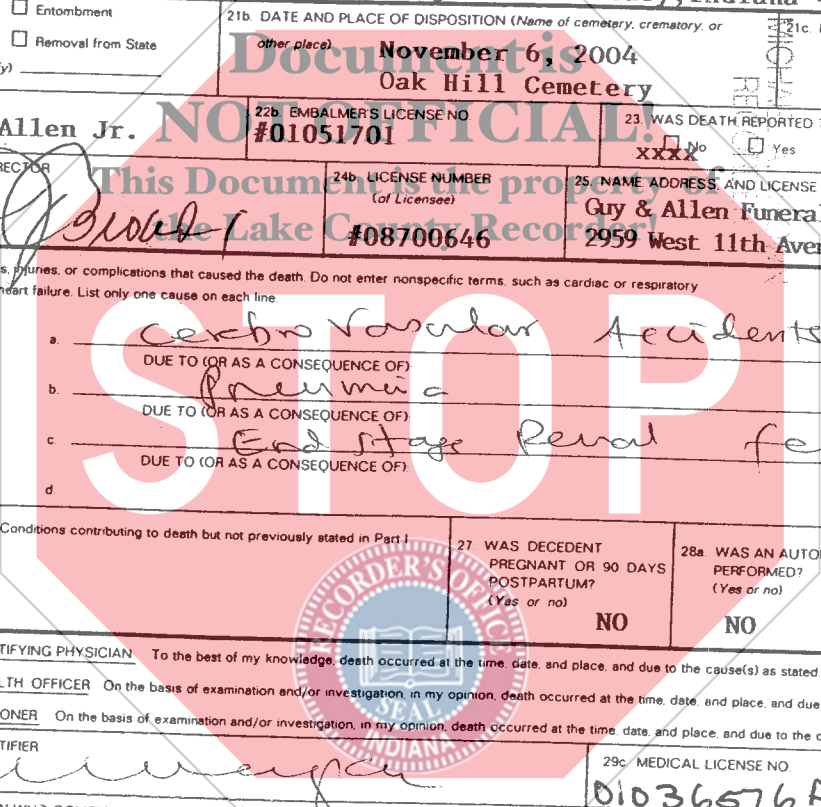
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Nathaniel F. Coleman</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>10:00p<sub>M</sub></b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>October 29, 2004</b>
4. *SOCIAL SECURITY NUMBER <b>304-34-3760</b>		5a. AGE—Last Birthday (Years) <b>68</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>September 19, 1936</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		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 checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>Clark Nursing &amp; Rehabilitation</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Gary</b>		COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Berthena Morgan</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Bricklayer</b>		12b. KIND OF BUSINESS/INDUSTRY <b>USX Steel Corp.</b>
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>2200 Wright Street</b>
13e. ZIP CODE <b>46404</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify) <b>Black</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5 +)				
18. FATHER'S NAME (First, Middle, Last) <b>Houston Coleman Sr.</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Dailey</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Berthena Coleman</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2200 Wright Street Gary, Indiana 46404</b>			20c. Relationship <b>Wife</b>
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <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) <b>November 6, 2004 Oak Hill Cemetery</b>		21c. LOCATION—City or Town, State <b>Gary, Indiana</b>		
22a. EMBALMER'S NAME <b>Roosevelt Allen Jr.</b>		22b. EMBALMER'S LICENSE NO. <b>#01051701</b>		23. WAS DEATH REPORTED TO CDORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>#08700646</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Gry &amp; Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404</b>		
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. <b>Cerebrovascular Accidents</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF) c. <b>End Stage Renal failure</b> DUE TO (OR AS A CONSEQUENCE OF) d.  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) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		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) as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. MEDICAL LICENSE NO. <b>01036576A</b>		29d. DATE SIGNED (Month, Day, Year) <b>11-15-04</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Umpathy 4802 Broadway Gary, Indiana 46408</b>						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) <b>NOV 17 2004</b>		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year) <b>JUN - 2 2005</b>		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED <b>000269</b>		34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) <b>STEPHEN R. STIGLICH LAKE COUNTY AUDITOR</b>				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)						
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						



FILED

9.02 JK CS