

Key # 49-36-7 49-36-4

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 287

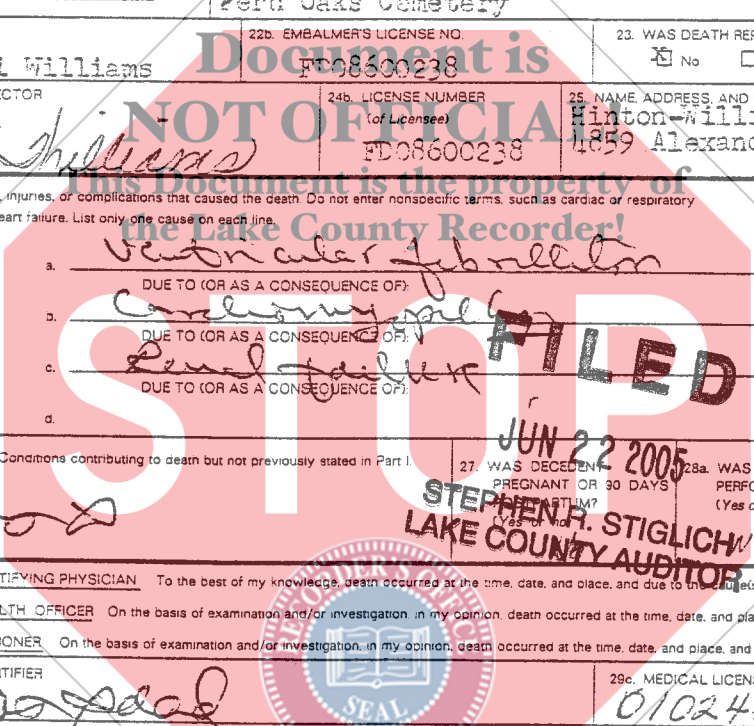
CERTIFICATE OF DEATH

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) <b>Eugene E. Ellis</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>1:10 P M</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>September 23, 1992</b>
4. SOCIAL SECURITY NUMBER <b>313-20-9131</b>	5a. AGE—Last Birthday (Years) <b>65</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>May 8, 1927</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>East Chicago, Indiana</b>				
8a. WAS DECEASED A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>NA</b>	9a. PLACE OF DEATH (Check only one. See instructions.) <b>HOSPITAL</b> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <b>OTHER</b> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>St. Catherine Hospital</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>East Chicago</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Bessie Jenkins</b>	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use "retired") <b>Operator (Retired)</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Inland Steel Co.</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>2362 Clark Road</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 DECEASED 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) <b>Black</b>
17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+)				
18. FATHER'S NAME (First, Middle, Last) <b>Elbert Ellis</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Essie Thomas</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Bessie Ellis</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2362 Clark Road Gary, Indiana 46404</b>		20c. Relationship <b>Wife</b>
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>September 26, 1992 Fern Oaks Cemetery</b>		21c. LOCATION—City, Town, State <b>Griffith, Indiana</b>
22a. EMBALMER'S NAME <b>Tracy Cheri Williams</b>		22b. EMBALMER'S LICENSE NO. <b>FD08600238</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b. LICENSE NUMBER (of Licensee) <b>FD08600238</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Hinton-Williams Funeral Home FH830016 4859 Alexander Ave. East Chicago, In. 46310</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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death)				
a. <b>ventricular fibrillation</b>				
DUE TO (OR AS A CONSEQUENCE OF):				
b. <b>conduction system</b>				
DUE TO (OR AS A CONSEQUENCE OF):				
c. <b>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 DECEASED PREGNANT OR 90 DAYS POSTPARTUM? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 <i>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>01024802</b>	29d. DATE SIGNED (Month, Day, Year) <b>9/25/92</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>WAMBI ADAD 8320 KENNEDY AV. HIGHLAND, IN 46320</b>				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) <b>9-25-92</b>
33. MANNER OF DEATH				
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide				
34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED <b>601858</b>
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.		



2005  
 05/15/6  
 2005 JUN 22  
 MICHAEL A. ...  
 RECORDED  
 FILED FOR ...  
 STATE OF INDIANA  
 LAKE COUNTY

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY