

25-44-0318-0010 BCC

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No.

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

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. 030996

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED-NAME (First, Middle, Last) Ester Taylor		2. SEX Female		3a. TIME OF DEATH 9:34 A M		3b. DATE OF DEATH (Month, Day, Yr.) July 05, 2003	
4. SOCIAL SECURITY NUMBER 421-36-5605		5a. AGE--Last Birthday (Years) 74		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:	
6. DATE OF BIRTH (Mo, Day, Yr.) April 13, 1929		7. BIRTHPLACE (City and State or Foreign Country) Selma, Alabama		8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	
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		9b. FACILITY NAME (If not institution, give street and number) 1072 Harrison Street		9c. CITY, TOWN, OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) None		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Truck Driver		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 1072 Harrison Street	
13e. ZIP CODE 46402		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) 10 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Ruben Monk		19. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Beatrice Young	
20a. INFORMANT'S NAME (Type/Print) Roy Lee Jackson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1072 Harrison Street Gary, Indiana 46402		20c. Relationship Fiancee'		21. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) July 12, 2003 Oak Hill Cemetery	
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)		22a. EMBALMER'S NAME Sherman G. Banks III		22b. EMBALMER'S LICENSE NO. FD 01016254		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licenses) FD 01016254		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner Funeral Home, PH19600034 4209 Grant St, Gary, IN, 46408		26. PART I. Enter the disease, 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. Vascular collapse DUE TO (OR AS A CONSEQUENCE OF): Due to arteriosclerotic heart and vascular disease	
26. 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 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 checked="" 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> David J. Pastreik, Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307		29c. MEDICAL LICENSE NO. N/A		29d. DATE SIGNED (Month, Day, Year) July 17, 2003	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) David J. Pastreik, Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307		31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) JUL 18 2003		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"/> Could not be Determined <input type="checkbox"/> Homicide	
34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY (Type or Cause)		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) July 5, 2003		34h. MOTOR VEHICLE (If yes, specify driver, passenger, pedestrian, etc.)	

DECEDENT

PARENTS

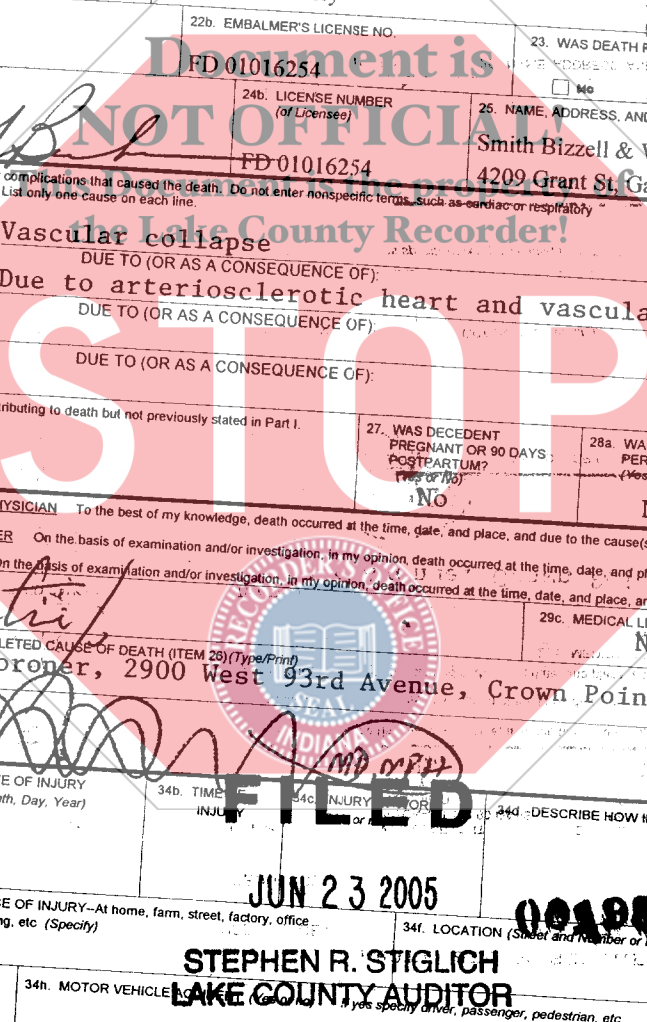
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



2005 09 28 032

FILED
LAKE COUNTY REC'D

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