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. 04 0341

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): Joyce Ann Long Green

2 SEX: Female

3a TIME OF DEATH: 2:19 P.M.

3b DATE OF DEATH (Month, Day, Yr.): May 27, 2004

4 *SOCIAL SECURITY NUMBER: 305-72-5998

5a AGE—Last Birthday (Years): 42

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo. Day. Yr.): January 24, 1962

7 BIRTHPLACE (City and State or Foreign Country): Gary, In

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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number): Methodist Northlake Hospital

9c CITY, TOWN, OR LOCATION OF DEATH: Gary

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Willie Green

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintainance Supply

12b KIND OF BUSINESS/INDUSTRY: Postal Service

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Gary

13d STREET AND NUMBER: 3360 W. 19th. Pl

13e ZIP CODE: 46404

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? USA

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Wash Williams

19 MOTHER'S NAME (First, Middle, Maiden Surname): Polly Ann Douglas

INFORMANT

20a INFORMANT'S NAME (Type/Print): Willie Green

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3360 W. 19th. Pl Gary, In 46404

20c Relationship: Husband

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____ [ ] Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 3, 2004 Oakhill Cemetery

21c LOCATION—City or Town, State: Gary, In

22a EMBALMER'S NAME: Avis Robinson

22b EMBALMER'S LICENSE NO.: FD 29700012

23 WAS DEATH REPORTED TO CORONER? [ ] No [X] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Avis Robinson

24b LICENSE NUMBER (of Licensee): FD 29700012

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Alpha Mortuary FH 19900030 421 W. 5th Ave., Gary, In 46402

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. Massive pulmonary thromboemboli

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death: Unknown

47-37-43 (35)
47-37-44
47-37-43

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): Yes

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

CERTIFIER

29a CERTIFIER (Check only one): Chief Deputy
[ ] 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.
[X] 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: N/A

29d DATE SIGNED (Month, Day, Year): June 1, 2004

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Jeffrey R. Wells, Chief Deputy, 2900 West 93rd Avenue, Crown Point, Indiana 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE:

32 DATE FILED (Month, Day, Year): JUN 01 2004

33 MANNER OF DEATH: [X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

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): May 27, 2004

34h MOTOR VEHICLE ACCIDENT? (Yes or no) - If yes, specify driver, passenger, pedestrian, etc.

TICOR MO 92004827