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.

10CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 495-02

State No. Key # 15-279-4

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): Mattie Bell Townsend
2. SEX: Female
3a. TIME OF DEATH: 6:20 a M
3b. DATE OF DEATH (Month, Day, Yr.): February 16, 2002
4. *SOCIAL SECURITY NUMBER: 499-28-5963
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): April 29, 1928
7. BIRTHPLACE (City and State or Foreign Country): East Prairie, Missouri
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 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): Leroy Townsend
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 5500 Tyler Street
13e. ZIP CODE: 46410
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes
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): Ophelia Smith
19. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Wallace

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Leroy Townsend
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5500 Tyler Street Merrillville, Indiana 46410
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [ ] Cremation [X] Removal from State [ ] Donation [ ] Other (Specify) _____ [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 22, 2002 St. Peters Cemetery
21c. LOCATION—City or Town, State: St. Louis, Missouri
22a. EMBALMER'S NAME: Roosevelt Allen Jr.
22b. EMBALMER'S LICENSE NO.: #0151701
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Valerie Woodard
24b. LICENSE NUMBER (of Licensee): #08700646
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. Metastatic Pancreatic Ca
DUE TO (OR AS A CONSEQUENCE OF):
b. Malignant pleural effusion
DUE TO (OR AS A CONSEQUENCE OF):
c. RT LL pneumonia
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.

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): [X] 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: [illegible]
29c. MEDICAL LICENSE NO.: 044462
29d. DATE SIGNED (Month, Day, Year): 2-26-02
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 6200 CLARK ST GARY IN 46402 Dr. Hassan

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan M Bustos
32. DATE FILED (Month, Day, Year): 2/28/2002

33. MANNER OF DEATH: [X] 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.):

FILED JUN 28 2005 STEPHEN B. STOLICH LAKE COUNTY AUDITOR

002290

SDH 06-004 State Form 10110 (R5/1-00)