ATTENTION ESTATE: The Social Security # is ...ing requested by this state agency in order to ...rsue its statutory responsibility. Disclosure is ...luntary and there will be no penalty for refusal.

Key # 47-427-14

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1496-05

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): WILLIE WILLIAMS
2. SEX: MALE
3a. TIME OF DEATH: 8:20 A.M.
3b. DATE OF DEATH (Month, Day, Yr.): MAY 26, 2005
4. *SOCIAL SECURITY NUMBER: 346-30-1399
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): June 2, 1931
7. BIRTHPLACE (City and State or Foreign Country): Marianna, Arkansas
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): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Ella Gilyard
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: Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2286 McKinley St.
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): 8; College (1-4 or 5 +): N.A

PARENTS

18. FATHER'S NAME (First, Middle, Last): Jessie Williams
19. MOTHER'S NAME (First, Middle, Maiden Surname): Willie Motley

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ella Williams
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2286 McKinley St. Gary, In 46404
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 3, 2005 Concordia Cemetery
21c. LOCATION—City or Town, State: Hammond, IN
22a. EMBALMER'S NAME: Avis Robinson
22b. EMBALMER'S LICENSE NO.: FD29700012
23. WAS DEATH REPORTED TO CORONER? [ ] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Avis Robinson
24b. LICENSE NUMBER (of Licensee): FD29700012
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Alpha Mortuary FH19900030 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. CARDIO - Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF): c. Diseased Arteriosclerosis
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: a Respiratory Failure; b Renal Failure; c PNEUMONIA

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): N/A

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: Feliciano F. Jimenez M.D.
29c. MEDICAL LICENSE NO.: 01021655A
29d. DATE SIGNED (Month, Day, Year): MAY 27 2005

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): FELICIANO F. JIMENEZ, M.D. 800 MACARTHUR BLVD. MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.
32. DATE FILED (Month, Day, Year): MAY 24 2005

33. MANNER OF DEATH: [ ] 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 31 2005
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

002539

SDH06-004 State Form 10110 (R5/1-99)