

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

INDIANA STATE DEPARTMENT OF HEALTH

Key # 47-427-14

Local No. 1496-05

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

REPRINT IN PERMANENT INK

DECEDENT

PARENTS

INFORMANT

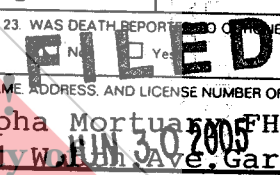
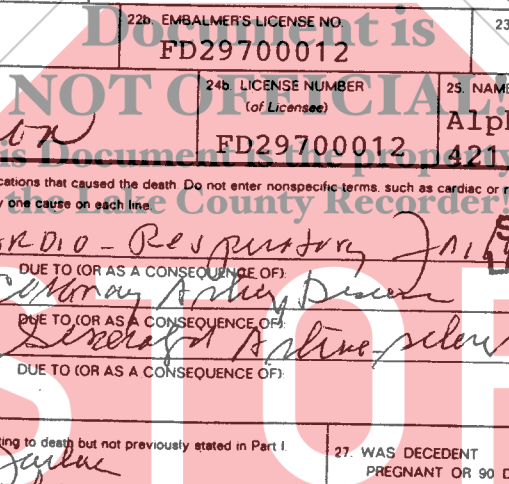
DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>WILLIE WILLIAMS</b>				2. SEX <b>MALE</b>	3a. TIME OF DEATH <b>8:20 A.M.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>MAY 26, 2005</b>
4. *SOCIAL SECURITY NUMBER <b>346-30-1399</b>	5a. AGE—Last Birthday (Years) <b>73</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>June 2, 1931</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Marianna, Arkansas</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			9b. FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>	
9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>			9d. COUNTY OF DEATH <b>LAKE</b>			
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Ella Gilyard</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Truck driver</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Steel</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>2286 McKinley St.</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>USA</b>	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) <b>Black</b>	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>N.A</b>	
18. FATHER'S NAME (First, Middle, Last) <b>Jessie Williams</b>			19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Willie Motley</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Ella Williams</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2286 McKinley St. Gary, In 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>June 3, 2005 Concordia Cemetery</b>		21c. LOCATION—City or Town, State <b>Hammond, IN</b>		
22a. EMBALMER'S NAME <b>Avis Robinson</b>		22b. EMBALMER'S LICENSE NO. <b>FD29700012</b>		23. WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Avis Roberson</i>		24b. LICENSE NUMBER (of Licensee) <b>FD29700012</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Alpha Mortuary, FH19900030 421 W. Main Ave. Gary, In 46402</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. <b>Cardio-Respiratory Failure</b> <b>Coronary Artery Disease</b> <b>Secondary Asthma</b>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>
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>Feliciano F. Jimenez, M.D.</i>		29c. MEDICAL LICENSE NO. <b>01021655A</b>		29d. DATE SIGNED (Month, Day, Year) <b>MAY 27, 2005</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>FELICIANO F. JIMENEZ, M.D. 800 MACARTHUR BLVD. MUNSTER, INDIANA 46321</b>		31. HEALTH OFFICER'S SIGNATURE <i>Susan W. But...</i>		32. DATE FILED (Month, Day, Year) <b>MAY 31 2005</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 DEATH OCCURRED OR COMPLETE LAKE COUNTY HEALTH DEPARTMENT FILE WITH THE <b>MAY 31 2005</b>	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <b>002.509</b>				



STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

47-427-14