Key # 49-393-2

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. 3193-01

4CC

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

2005 081956

DECEDENT

Field	Entry
1 DECEASED—NAME (First, Middle, Last)	Ruth L. Guerdon
2 SEX	Female
3a TIME OF DEATH	5:00 PM
3b DATE OF DEATH (Month, Day, Yr.)	December 17, 2001
4 *SOCIAL SECURITY NUMBER	305-50-4279
5a AGE—Last Birthday (Years)	86
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo., Day, Yr.)	October 21, 1915
7 BIRTHPLACE (City and State or Foreign Country)	Memphis, Tennesse
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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☒ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number)	Southlake Nursing & Rehabilitation Center
9c CITY, TOWN, OR LOCATION OF DEATH	Merrillville
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Widowed
11 SURVIVING SPOUSE (If wife, give maiden name)	N/A
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	Beautician
12b KIND OF BUSINESS/INDUSTRY	Self Employed
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	Merrillville
13d STREET AND NUMBER	8800 Virginia Place
13e ZIP CODE	46410
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	USA
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ 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

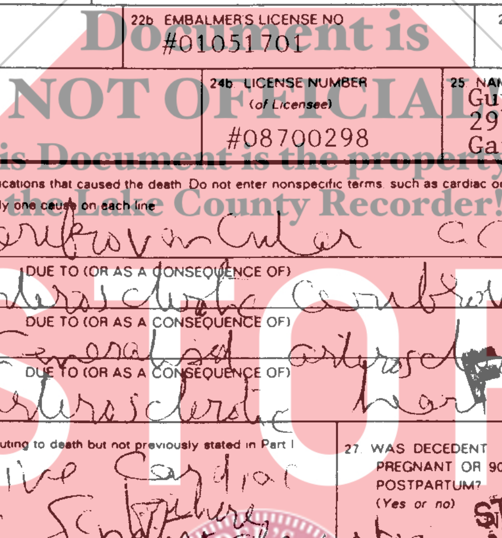
Field	Entry
18 FATHER'S NAME (First, Middle, Last)	King Chavers
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Evie Elder

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Pamela Powers
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	9151 Wright Street Merrillville, Indiana 46410
20c Relationship	Daughter

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	December 21, 2001 Fern Oak Cemetery
21c LOCATION—City or Town, State	Griffith, Indiana
22a EMBALMER'S NAME	Roosevelt Allen Jr.
22b EMBALMER'S LICENSE NO.	#01051701
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	#08700298
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Guy & Allen Funeral Director, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704



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STOP

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. cerebrovascular accident

DUE TO (OR AS A CONSEQUENCE OF)

b. arteriosclerotic cerebrovascular disease

DUE TO (OR AS A CONSEQUENCE OF)

c. Generalized arteriosclerosis

DUE TO (OR AS A CONSEQUENCE OF)

d. arteriosclerotic heart disease

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Congestive Cardiac Failure, arteriosclerotic [illegible] dementia

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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)

☒ 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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO.	IN 25043
29d DATE SIGNED (Month, Day, Year)	12/31/2001
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Kristinan Patima 8300 Broadway Merrillville IN 46410

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Susan J. Burt D.O.
32 DATE FILED (Month, Day, Year)	[illegible]

Field	Entry
33 MANNER OF DEATH	☒ 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.	

9407

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