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Key # 45-241-27

INDIANA STATE DEPARTMENT OF HEALTH

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.

CERTIFICATE OF DEATH

State No.

Local No. #05-634

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) John S. Adams				2. SEX Male		3a. TIME OF DEATH 5:16A M		3b. DATE OF DEATH (Month, Day, Year) November 15, 2005	
4. *SOCIAL SECURITY NUMBER 407-14-4203		5a. AGE—Last Birthday (Years) 87		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) September 15, 1918	
7. BIRTHPLACE (City and State or Foreign Country) Stanley, Kentucky		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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence							
9b. FACILITY NAME (If not institution, give street and number) 1100 North Vanderburg Street				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) Mildred Jamison		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Manager			12b. KIND OF BUSINESS/INDUSTRY Budd Company		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary			13d. STREET AND NUMBER 1100 North Vanderburg Street		
13e. ZIP CODE 46403		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U S A		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) Black	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 12th		18. FATHER'S NAME (First, Middle, Last) John Adams				19. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa Taylor			
20a. INFORMANT'S NAME (Type/Print) Mildred Adams				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 N. Vanderburg ST. Gary, Indiana 46403				20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) November 19, 2005 Oak Hill Cemetery				21c. LOCATION—City or Town, State Gary, Indiana		
22a. EMBALMER'S NAME Taquia Addison		22b. EMBALMER'S LICENSE NO. #20500009		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes					
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Carmelita Perry</i>		24b. LICENSE NUMBER (of Licensee) #29700070		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704					
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. <i>myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>Paget's Disease</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) No		Approximate Interval Between Onset and Death <i>4 minutes</i>			
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>D.L. Fortson, MD</i>		29c. MEDICAL LICENSE NO. 01037803		29d. DATE SIGNED (Month, Day, Year) 11/17/05			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) <i>D.L. Fortson, MD 9727 Prairie Highlands</i>									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>									
32. FILED FOR RECORDING (Month, Day, Year) FEB 06 2006		33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 INJURY OCCURRED <i>FILED</i>			
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) <i>PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR</i>							
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <i>2493</i>						

DECEDENT

PARENTS

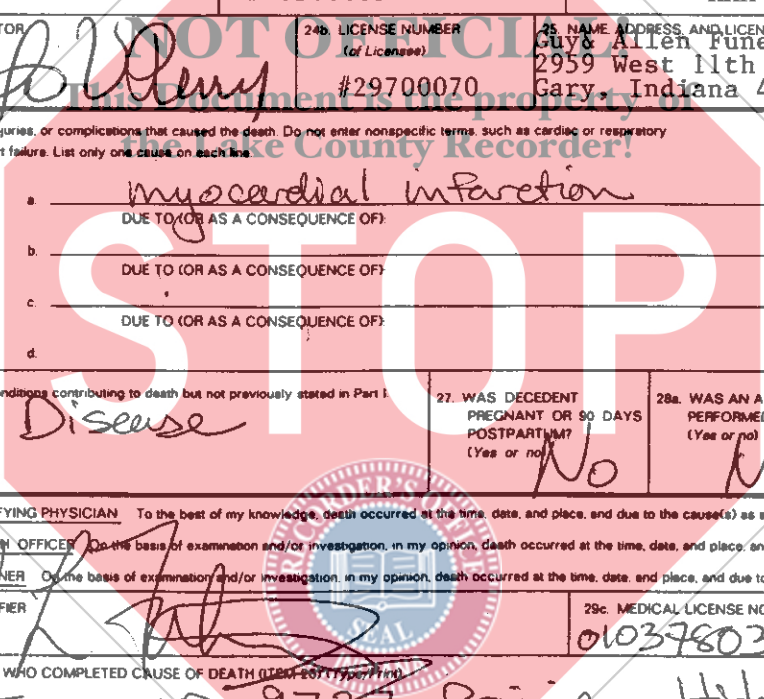
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



FILED FEB 06 2006 5 PM 0:17
NICHOLE A. BROWN
RECORDER
LAKE COUNTY INDIANA
REC'D FOR RECORDING
#15 CS
2493

Prescribed by the
State Board of Accounts
(2005)

County form 170

Declaration

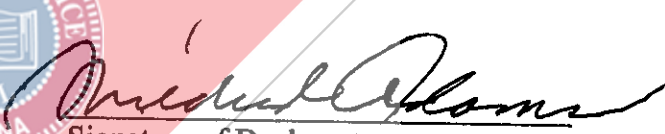
This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number in attached document.
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.




Signature of Declarant

MILDRED ADAMS
Printed Name of Declarant