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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 3879-05

State No. _____

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

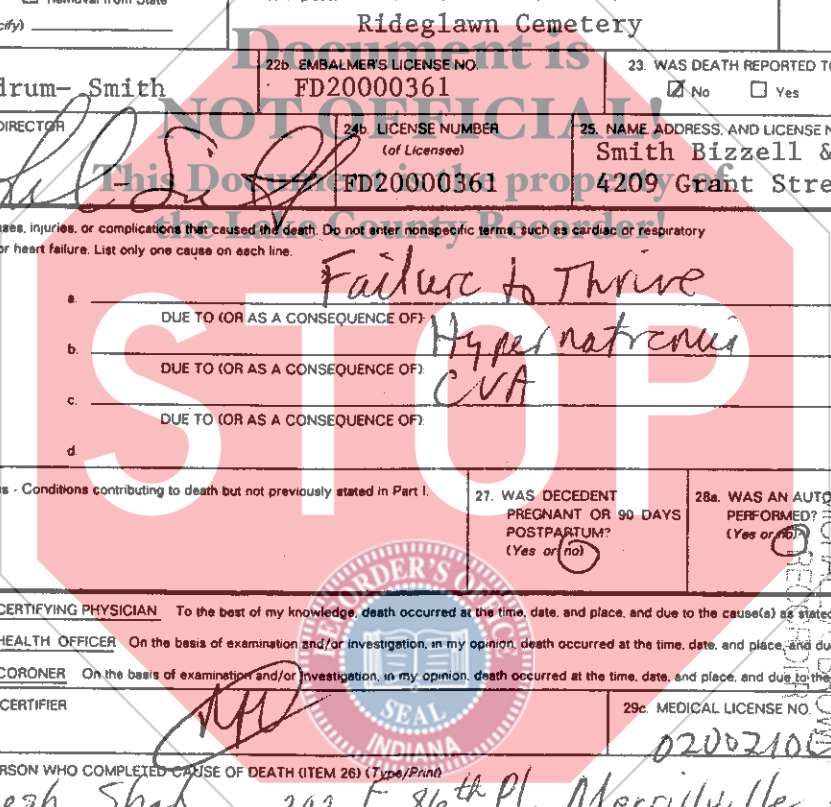
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Silas Taylor		2. SEX Male	3a. TIME OF DEATH 7:48P M	3b. DATE OF DEATH (Month, Day, Yr.) November 3, 2005	
4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years) 84	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) May 13, 1921	
7. BIRTHPLACE (City and State or Foreign Country) Butler, Alabama	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	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) <input type="checkbox"/> 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) Mirtha Hampton	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Stove Man	12b. KIND OF BUSINESS/INDUSTRY LTV Steel		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 1765 Hayes Street		
13e. ZIP CODE 46404	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) 6 College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) Jim Taylor			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ruffin			20. INFORMANT'S NAME (Type/Print) Jacqueline Green		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9801 Broadmoor Lane Rowlett, Texas 75089		20c. Relationship Daughter			
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) November 10, 2005 Rideglawn Cemetery		21c. LOCATION—City or Town, State Gary, Indiana	
22a. EMBALMER'S NAME Yolanda Landrum-Smith		22b. EMBALMER'S LICENSE NO. FD20000361	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD20000361	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner Funeral Home 4209 Grant Street Gary, Indiana 46408		
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. Failure to Thrive Hypertension CVA		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
29a. CERTIFIER (Check only one) <input 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 checked="" 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 of death as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> HEALTH OFFICER			
29c. MEDICAL LICENSE NO. 02002100		29d. DATE SIGNED (Month, Day, Year) 11/10/05			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Rupesh Shah 202 E. 86th Pl. Merrillville IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> HEALTH OFFICER					
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) FEB 09 2006	34b. INJURY AT WORK? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	34c. DESCRIBE HOW INJURY OCCURRED NOV 17 2005	
34d. PLACE OF INJURY (Home, farm, school, factory, office, building, etc. (Specify)) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 02793			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. CAN			

25-42-0058-0033
Central Park Add N 20ft Lot 30 + Sign of Lot 31 Block 1



20060784
PH19600034
MICHAEL BROWN
STATE OF INDIANA
DEPT OF HEALTH
LAKE COUNTY
HEALTH OFFICER
NOV 17 2005

Prescribed by the
State Board of Accounts
(2005)

County form 170

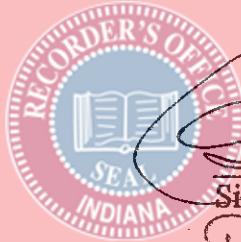
Declaration

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

Bessie M Taylor
Printed Name of Declarant