...THIS COUNTY'S HEALTH DEPARTMENT

079076

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. ....

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 44-300-40

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): Adell Williams			2. SEX: Male	3a. TIME OF DEATH: 3:30 p. M	3b. DATE OF DEATH (Month, Day, Yr): March 18, 2006	
4. *SOCIAL SECURITY NUMBER: 313-36-2604	5a. AGE—Last Birthday (Years): 75	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr): May 15, 1930	7. BIRTHPLACE (City and State or Foreign Country): Valden Mississippi	
8a. WAS DECEDENT A U.S. VETERAN?: Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1953	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): St. Catherine Hopital			9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago		9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): Edna D. Purnell		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Crane Operator		12b. KIND OF BUSINESS/INDUSTRY: Inland Steel	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Gary		13d. STREET AND NUMBER: 1129 Tyler Street		
13e. ZIP CODE: 46407	13f. INSIDE CITY LIMITS: ☐ No ☒ Yes; 13g. ON A FARM?: ☒ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY?: USA	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 9; College (1-4 or 5+): N/A	

PARENTS

18. FATHER'S NAME (First, Middle, Last): Earlene Williams	19. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Gaines

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Edna Williams	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1129 Tyler Street, Gary, IN 4640	20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 25, 2006 Oak Hill CEMETERY	21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III	22b. EMBALMER'S LICENSE NO.: FD01016254	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): FD01016254	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner FH10500021 4209 Grant Street, Gary, Indiana

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. cardio-respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiac desrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
c. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

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.

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

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. MEDICAL LICENSE NO.: 01032690	29d. DATE SIGNED (Month, Day, Year): 4-12-06

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Sami Ahmadzai, MD 6924 Indianapolis Blvd. Hammond IN 46324

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD

32. DATE FILED (Month, Day, Year): 3/29/06

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): March 18, 2006	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

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FILED AUG - 9 2006 GAKATONA LAKE COUNTY AUDITOR

2006 AUG - 9 PM 2:31 FILED FOR RECORD

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT