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PORTER COUNTY
CERTIFICATE OF DEATH

PORTER COUNTY
HEALTH DEPARTMENT
155 Indiana Ave Suite 104
Valparaiso IN 46383

580912

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last): WOODROW WILSON BARNES
2. SEX: Male
3a. TIME OF DEATH: 3:45p.M
3b. DATE OF DEATH (Month, Day, Yr.): May 2, 2004
4. SOCIAL SECURITY NUMBER: 317-09-2302
5a. AGE—Last Birthday (Years): 91
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Nov. 8,1912
7. BIRTHPLACE (City and State or Foreign Country): Obion Co. Tennessee
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1940
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): Fountainview Nursing Home
9c. CITY, TOWN, OR LOCATION OF DEATH: Portage
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name):
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Retired Steelworker
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 356 S. Sullivan St.
13e. ZIP CODE: 46403
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): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

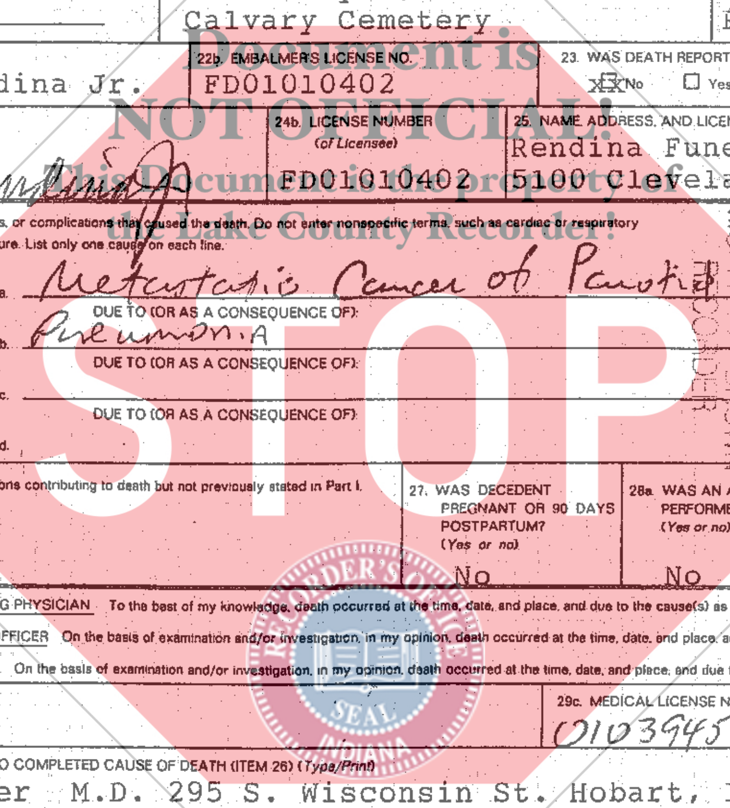
18. FATHER'S NAME (First, Middle, Last): Samuel Barnes
19. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Woods

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Linda Barnes
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 356 S. Sullivan St. Gary, In46403
20c. Relationship: Daughterinlaw

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): May 7, 2004 Calvary Cemetery
21c. LOCATION—City or Town, State: Portage, Indiana
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.
22b. EMBALMER'S LICENSE NO.: FD01010402
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S. Rendina Jr.
24b. LICENSE NUMBER (of Licensee): FD01010402
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina Funeral Home FH83007819 5100 Cleveland St. Gary,In 46408



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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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Metastatic Cancer of Parotid Gland — Approximate Interval Between Onset and Death: Unknown

DUE TO (OR AS A CONSEQUENCE OF):

b. Pneumonia — 1 month

DUE TO (OR AS A CONSEQUENCE OF):

c.

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):

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.: 01039453
29d. DATE SIGNED (Month, Day, Year): 5/4/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. E. Carter M.D. 295 S. Wisconsin St. Hobart, Indiana 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Mary A. Bobroke MD
32. DATE FILED (Month, Day, Year): May 5, 2004

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.

Lt19 + N10' Lt18, Block "H" Inland Manor 3rd Add to Gary
Key # 45-86-19

2006 AUG 16 AM 9:01
FILED FOR RECORD

FILED
AUG 15 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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

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