

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 04 0153

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

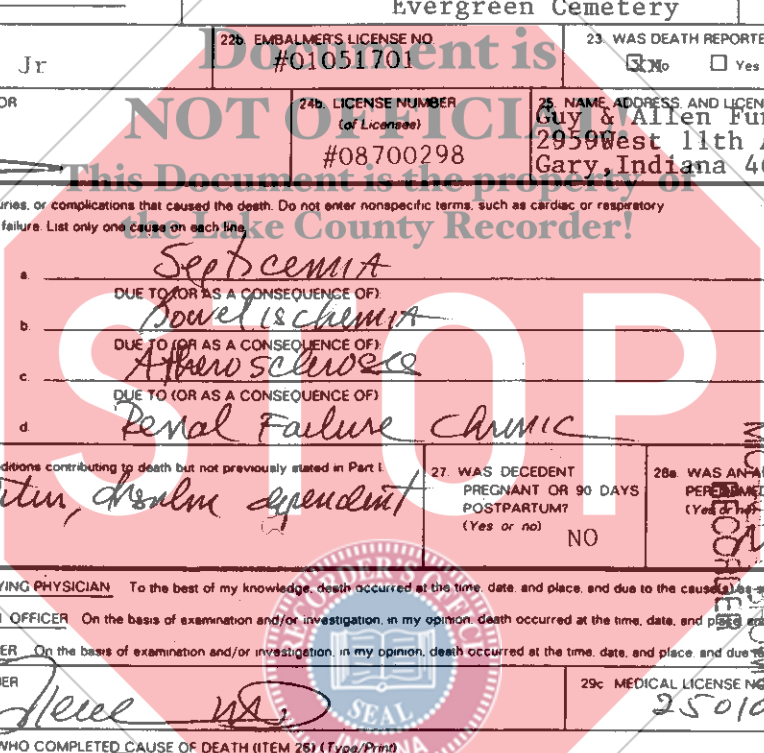
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Walter Lee Taylor Sr.		2. SEX Male	3a. TIME OF DEATH 6:30 P M	3b. DATE OF DEATH (Month, Day, Yr.) March 10, 2004	
4. SOCIAL SECURITY NUMBER 426-58-5520	5a. AGE—Last Birthday (Years) 70	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) December 29, 1933	
7. BIRTHPLACE (City and State or Foreign Country) Edwards, Mississippi	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 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 Northlake		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) Geraldine Scott	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Switchman	12b. KIND OF BUSINESS/INDUSTRY LTV Steel Corp.		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Gary	13d. STREET AND NUMBER 4801 West 9th Avenue		
13e. ZIP CODE 46408	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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. DECEASED'S EDUCATION (Specify only highest grade completed) 10th		18. FATHER'S NAME (First, Middle, Last) L. C. Lee			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Jones		20a. INFORMANT'S NAME (Type/Print) Geraldine Taylor			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 West 9th Avenue Gary, Indiana 46406		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) March 16, 2004 Evergreen Cemetery		21c. LOCATION—City or Town, State Gobart, Indiana	
22a. EMBALMER'S NAME Roosevelt Allen Jr		22b. EMBALMER'S LICENSE NO. #01051701	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR		24b. LICENSE NUMBER (of Licensee) #08700298	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, INC 2959 West 11th Avenue Gary, Indiana 46406 83007704		
25. 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>Septicemia</i>		Approximate Interval Between Onset and Death 1 day	
b. <i>Bowel ischemia</i>		c. <i>Arterio sclerosis</i>		1 day	
d. <i>Renal Failure chronic</i>				Years	
PART II Other significant conditions Conditions contributing to death but not previously stated in Part I <i>Diabetes mellitus, insulin dependent</i>					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
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) listed. <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) listed. <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>WJ Pierce MD</i>		29c. MEDICAL LICENSE NO. 25010	29d. DATE SIGNED (Month, Day, Year) 2/19/14		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) <i>William J. Pierce MD</i>					
31. HEALTH OFFICER'S SIGNATURE <i>William J. Pierce MD</i>			32. DATE FILED (Month, Day, Year) MAR 26 2004		
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. PLACE OF INJURY (Specify) AUG 21 2006	34d. DESCRIBE HOW INJURY OCCURRED 015902 \$11 CS
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no)			

Oakland Realty Co's Sub Lot 1 & E10ft lot 2 Block 1 25-46-0115-001

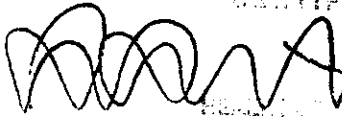


2006 AUG 21 AM 9:12

FILED FOR RECORDER

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR



CERTIFIED BY

RECORDER
CITY OF CORY, IND.
MAR 2 6 2004