

* 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.

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INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. **98-0758**

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) Watson Kindred		2 SEX Male	3a TIME OF DEATH 7:10 A	3b DATE OF DEATH (Month, Day, Year) October 20, 1998	
4 SOCIAL SECURITY NUMBER 424-12-6396	5a AGE—Last Birthday (Years) 74	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo., Day, Yr) April 12, 1924	
7 BIRTHPLACE (City and State or Foreign Country) Opelika, Alabama	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 checked="" type="checkbox"/> 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) Princie M. Fears	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Custodian		12b KIND OF BUSINESS/INDUSTRY Post-Tribune	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY/TOWN OR LOCATION Gary		13d STREET AND NUMBER 2385 Lincoln Street	
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5 +)		18 FATHER'S NAME (First, Middle, Last) Cleve Kindred			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Castoria Hunter		20a INFORMANT'S NAME (Type/Print) Princie M. Kindred			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2385 Lincoln Street Gary, Indiana 46407		20c Relationship Wife			
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) October 26, 1998 Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana	
22a EMBALMER'S NAME Rosenwald D. Allen Jr		22b EMBALMER'S LICENSE NO. #29400047		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licenses) #08700646		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 W. 11th Avenue Gary, Indiana 46404	
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. Coronary artery disease, heart failure DUE TO (OR AS A CONSEQUENCE OF) Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) Coronary artery disease					
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)	
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>[Signature]</i>		29c MEDICAL LICENSE NO. 114759	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. B. Weiss 202 East 86th Avenue Merrillville, Indiana 46410					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month, Day, Year) NOV 10 1998		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year) AUG 29 2006	34b TIME OF INJURY 11:45	34c INJURY AT WORK? NO	
34d DESCRIBE HOW INJURY OCCURRED 1145 LS		34e PLACE OF INJURY—At home, farm, street, factory, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR			
34f DATE (Month, Day, Year)		34g MOTOR VEHICLE ACCIDENT? (Yes or no. If yes, specify driver, passenger, pedestrian, etc.) 016819			

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

25-43-0224-0048
Gary Park Add
lot 4B Block 5



20005
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20005
STATE OF INDIANA
LAKE COUNTY
FILED
20005