

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 930

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

Nov. 27, 2000 Date Issued
Franklin J. Presnada, M.D. Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Ray H. Dark		2 SEX Male	3a TIME OF DEATH 2:50 P.M.	3b DATE OF DEATH (Month Day Year) November 23, 2000	
4 *SOCIAL SECURITY NUMBER 410-50-9423	5a AGE—Last Birthday (Years) 66	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) September 13, 1934	
7 BIRTHPLACE (City and State or Foreign Country) Fayetteville, TN	8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES? None	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> SOA 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) St. Margaret Mercy, North Campus		9c CITY TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Barbara F. Lacewell	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Millwright		12b KIND OF BUSINESS/INDUSTRY LTV Steel Co.	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond	13d STREET AND NUMBER 3431-165th Street		
13e ZIP CODE 46323	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? USA	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) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (11-4 or 5+) _____			
18 FATHER'S NAME (First Middle Last) Charlie Dark		19 MOTHER'S NAME (First Middle Maiden Surname) Mary Stewart			
20a INFORMANT'S NAME (Type/Print) Barbara F. Dark		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3431-165th St., Hammond, IN 46323		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) November 27, 2000 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, IN	
22a EMBALMERS NAME Henry J. Blake		22b EMBALMERS LICENSE NO. FD01019406	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edwin B. Feltz</i>		24b LICENSE NUMBER (of Licensee) FD01000857	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc., FH19400005 6955 Southeastern Ave., Hammond, IN 46322		
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter non-specific 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. <u>Respiratory failure 2° Braun Stem infarct</u>		3-4 d	
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b. <u>Sepsis</u>		3 days	
c. _____		d. _____			
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		
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. 01052839	29d DATE SIGNED (Month Day Year) 11/24/00		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. C. W. Patel, M.D., 5500 Hohman Avenue, Suite 1D, Hammond, IN 46322					
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Presnada, M.D.</i>				32 DATE FILED (Month Day Year) November 27, 2000	
33 MANNER OF DEATH <input 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 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.			

