2cc

* 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

Local No. 03 0194 State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED–NAME (First, Middle, Last): Elsie Dry
2. SEX: Female
3a. TIME OF DEATH: 3:35 P M
3b. DATE OF DEATH (Month, Day, Yr.): March 19, 2003
4. *SOCIAL SECURITY NUMBER: [redacted]
5a. AGE–Last Birthday (Years): 92
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo. Day, Yr.): June 30, 1910
7. BIRTHPLACE (City and State or Foreign Country): Dyersburg, Tennessee
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
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): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE–STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 763 Ohio Street
13e. ZIP CODE: 46402
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 12 College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Unavailable
19. MOTHER'S NAME (First, Middle, Maiden Surname): (Unavailable) Harris

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Stevette Wilson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1822 Brookside Avenue Indianapolis, Indiana 46201
20c. Relationship: Granddaughter

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 26, 2003 Evergreen Memorial Park
21c. LOCATION–City or Town, State: Hobart, IN
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD20000361
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034 4209 Grant St, Gary, IN, 46408

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. Hematuria, Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive heart failure
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

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Bladder cancer
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No): No
28a. AUTOPSY PERFORMED? (Yes or No): No
28b. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No): No

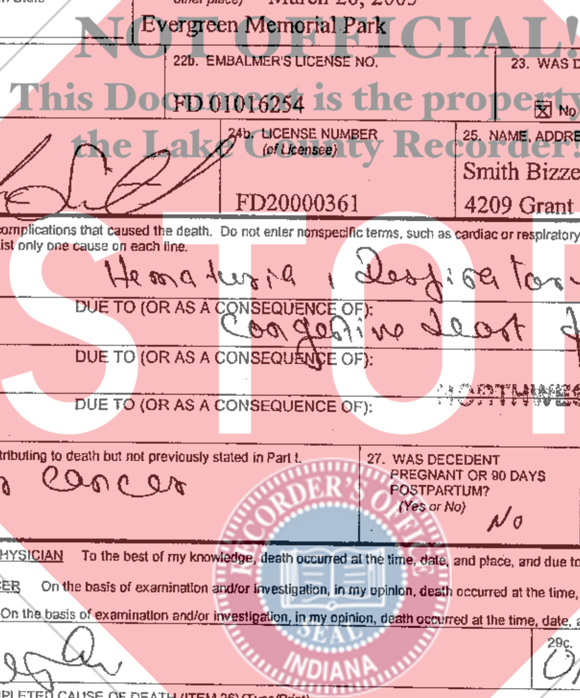
CERTIFIER

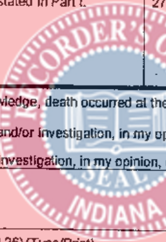
29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due 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.: 01027933
29d. DATE SIGNED (Month, Day, Year): 3-27-03
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 1400 Broadway Gary IN Dr. S. A. Desai

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD, MPH
32. DATE FILED (Month, Day, Year): APR 2003

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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.





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STOP

RECORDER'S OFFICE SEAL INDIANA

FILED DEC - 1 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

MICHAEL A. BROWN RECORDER

2006 106890

15909

NORTHWEST INDIANA TITLE SERVICES, INC. 102 Washington Street Lowell, Indiana 46356 219-696-0100

I AFFIRM UNDER THE PENALTIES FOR PERJURY THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT UNLESS REQUIRED BY LAW. Alice Caputo

024745

11– ZP

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KEY#44-332-16 LOT 16, IN BLOCK 1, IN RESUBDIVISION OF GARY LAND COMPANY'S THIRTEENTH SUBDIVISION, IN THE CITY OF GARY, AS PER PLAT OF SAID RESUBDIVISION, RECORDED IN PLAT BOOK 19 PAGE 10, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA