

* 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. 65

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

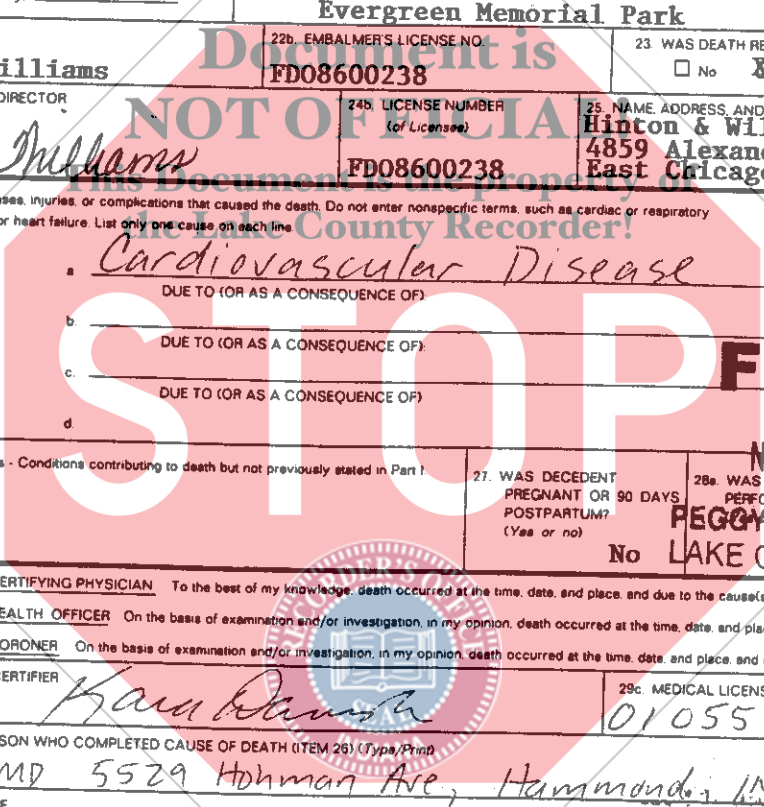
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

| | | | | |
|---|--|--|--|--|
| 1. DECEASED—NAME (First, Middle, Last) Lela M. Pitts | | 2. SEX Female | 3a. TIME OF DEATH 4:50A. M | 3b. DATE OF DEATH (Month, Day, Yr.) March 13, 2006 |
| 4. *SOCIAL SECURITY NUMBER 421-24-6528 | | 5a. AGE—Last Birthday (Years) 83 | 5b. UNDER 1 YEAR Months Days | 5c. UNDER 1 DAY Hours Minutes |
| 5d. DATE OF BIRTH (Mo, Day, Yr) September 28, 1922 | | 7. BIRTHPLACE (City and State or Foreign Country) Wetumpka, 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 type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence | | |
| 9b. FACILITY NAME (If not institution, give street and number) 4844 Melville Avenue | | 9c. CITY, TOWN, OR LOCATION OF DEATH East Chicago | 9d. COUNTY OF DEATH Lake | |
| 10. MARITAL STATUS (Specify) Widow | 11. SURVIVING SPOUSE (If wife, give maiden name) N/A | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Crossing Guard (retired) | | 12b. KIND OF BUSINESS/INDUSTRY City of East Chicago |
| 13a. RESIDENCE—STATE Indiana | 13b. COUNTY Lake | 13c. CITY, TOWN, OR LOCATION East Chicago | | 13d. STREET AND NUMBER 4844 Melville Avenue |
| 13e. ZIP CODE 46312 | 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) Black |
| 17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) 0 | | 18. FATHER'S NAME (First, Middle, Last) Jim Cook | | |
| 19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lyles | | 20. INFORMANT'S NAME (Type/Print) William O'Neal | | |
| 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 W. 140th St. East Chicago, IN 46312 | | 20c. Relationship Son | | |
| 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 18, 2006 Evergreen Memorial Park | | 21c. LOCATION—City or Town, State Hobart, Indiana |
| 22a. EMBALMER'S NAME Tracy Cheri Williams | | 22b. EMBALMER'S LICENSE NO. FD08600238 | 23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i> | | 24b. LICENSE NUMBER (of Licensee) FD08600238 | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Hinton & Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, IN 46312 FH83001520 | |
| 26. PART I. Enter the disease, 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) Cardiovascular Disease | | | | |
| DUE TO (OR AS A CONSEQUENCE OF) | | | | |
| DUE TO (OR AS A CONSEQUENCE OF) | | | | |
| DUE TO (OR AS A CONSEQUENCE OF) | | | | |
| DUE TO (OR AS A CONSEQUENCE OF) | | | | |
| 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? NO | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO REPORTING 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) as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kara Davis</i> | | 29c. MEDICAL LICENSE NO. 01055727 | 29d. DATE SIGNED (Month, Day, Year) 3/14/06 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) KARA DAVIS, MD 5529 Hohman Ave, Hammond, IN 46324 | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>Gabe Bonchuk, Auditor</i> | | | | 32. DATE FILED (Month, Day, Year) 3/15/06 |
| 33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide | | 34a. DATE OF INJURY (Month, Day, Year) NOV 30 2006 | 34b. TIME OF INJURY JU | 34c. INJURY AT WORK? (Yes or no) NO |
| 34d. DESCRIBE HOW INJURY OCCURRED \$11 | | 34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) NOV 30 2006 | | |
| 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 024801A CK# 1065 | | 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | | |
| 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR | | | | |



NOV 30 2006
LAKE COUNTY AUDITOR