

10cc + Free VETS

Key # 44-198-2

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue 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. **2006-06**

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

MENTS

FORMANT

POSITION

USE OF

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Lonnie B. Ford		2 SEX Male	3a TIME OF DEATH 7:36A M	3b DATE OF DEATH (Month, Day, Yr.) October 16, 2006	
4 *SOCIAL SECURITY NUMBER 305-30-2640	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.) March 5, 1932	
7 BIRTHPLACE (City and State or Foreign Country) Greenwood, Mississippi	8a WAS DECEDENT A U.S. VETERAN? YES				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1951	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 Southlake		9c CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Doris Brown	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Letter Carrier		12b KIND OF BUSINESS/INDUSTRY US Postal Service	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 609 Rutledge Street		
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) Elementary/Secondary (9-12) College (1-4 or 5 +) 2 Years	18 FATHER'S NAME (First, Middle, Last) John Ford				
19 MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Mae Williams				20e Relationship Wife	
20a INFORMANT'S NAME (Type/Print) Doris Ford		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Rutledge Street Gary, Indiana 46404			
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 21, 2006 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, 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"/> XXX <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) #08700646	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704		
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 <i>[Signature]</i> DUE TO (OR AS A CONSEQUENCE OF) b DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) 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)	
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. 01035956A	29d DATE SIGNED (Month, Day, Year) 10-23-06		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Abdullah 4802 Broadway Gary, Indiana 46408					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					
32 DATE FILED (Month, Day, Year) October 23, 2006					
33 MANNER OF DEATH <input checked="" 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)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED \$11 ES CK # 16490 CP
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.			

