

* 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

Key# 44-181-3

Local No. 06 0573

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) LueDella Ferguson				2. SEX Female	3a. TIME OF DEATH 5:50a _M	3b. DATE OF DEATH (Month, Day, Yr.) October 24, 2006
4. *SOCIAL SECURITY NUMBER 306-38-6888	5a. AGE—Last Birthday (Years) 69	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) August 25 1937	7. BIRTHPLACE (City and State or Foreign Country) Jackson, TN.	
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NO	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) Southlake Methodist Hospital			9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Divorced	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) Insurance Manager		12b. KIND OF BUSINESS/INDUSTRY Transportation		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 448 Garfield Street		
13e. ZIP CODE 46404	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input 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 (0-8) 12th 0 College (1-4 or 5+) 0	
18. FATHER'S NAME (First, Middle, Last) W.C.Thomason			19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Dell May			
20a. INFORMANT'S NAME (Type/Print) Reese L.Gault			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 448 Garfield Gary, In. 46404		20c. Relationship Son	
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 30, 2006 Evergreen Memorial Park		21c. LOCATION—City or Town, State Hobart, IN	
22a. EMBALMER'S NAME Belicia P.Hicks			22b. EMBALMER'S LICENSE NO. FDO29600125		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) 29600125		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Powell-Coleman Funeral Home 1901 Washington St. Gary, In. 88202434	
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) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last a. <i>myocarditis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>cardiac arrest</i> 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. <i>Dialysis,</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 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. 90726902		29d. DATE SIGNED (Month, Day, Year) 10/26/06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Harsh Dalal, 5825 Broadway Merrillville IN 46410						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32. DATE FILED (Month, Day, Year) OCT 27 2006	
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)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED DEC 13 2006 11-	
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) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR 24907		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian				