

* 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.

12CC + 3 Free VETS

INDIANA STATE DEPARTMENT OF HEALTH

Key # 43-187-14
47-122-6

CERTIFICATE OF DEATH

State No.

Local No. 04 0013

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

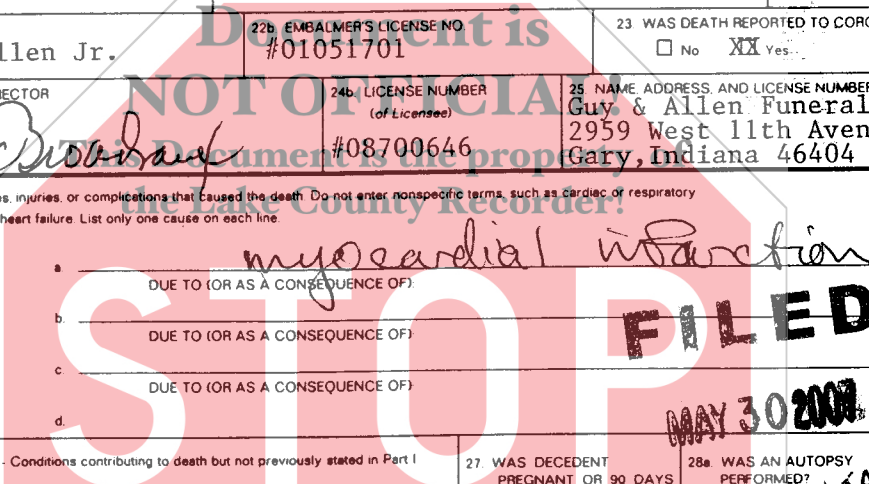
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Quentin T. Woods		2. SEX Male	3a. TIME OF DEATH 5:55 P	3b. DATE OF DEATH (Month, Day, Yr.) January 6, 2004
4. *SOCIAL SECURITY NUMBER 317-20-7959	5a. AGE—Last Birthday (Years) 78	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) February 27, 1925
8a. WAS DECEDENT A U.S. VETERAN? YES	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1955	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"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) 1540 Baker Street		9c. CITY, TOWN, OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS Married	11. SURVIVING SPOUSE (If wife, give maiden name) Doris Broadnax	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor	12b. KIND OF BUSINESS/INDUSTRY General Services	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 1540 Baker 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
18. FATHER'S NAME (First, Middle, Last) Mathias Woods		19. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Harris		
20a. INFORMANT'S NAME (Type/Print) Doris Woods		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1540 Baker Street Gary, Indiana 46404	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) January 9, 2004 Oak Hill Cemetery		21c. LOCATION—City or Town, State Gary, Indiana
22a. EMBALMER'S NAME Roosevelt Allen Jr.		22b. EMBALMER'S LICENSE NO. #01051701	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Broadnax</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) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last a. DUE TO (OR AS A CONSEQUENCE OF) myocardial infarction b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.				Approximate Interval Between Onset and Death
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I diabetes mellitus		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO LAKE	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO LAKE	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO LAKE
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>Alvin A Fortson</i>		29c. MEDICAL LICENSE NO. 01037803	29d. DATE SIGNED (Month, Day, Year) 1/12/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 2818 ... Dr. Fortson				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> MD, MPH			32. DATE FILED (Month, Day, Year) JAN 15 2004	
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"/> Homicide <input type="checkbox"/> Could not be Determined	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED 021364
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		



MAY 30 2007

11:00
D.S.
D.A.M.

44-205-4
44-205-5
44-205-12
48-54-13
43-187-14
43-381-1