

45-325-37

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. 1238-07

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Charles H. Woodard</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>2:35 AM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>May 6, 2007</b>	
4. *SOCIAL SECURITY NUMBER <b>316-05-5419</b>		5a. AGE—Last Birthday (Years) <b>84</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>January 23, 1923</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Greenville, S.C.</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>ARMY</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>		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 type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) <b>Lincolnshire HCC</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Spouse) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Mildred Sheffield</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Laborer</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Gary School Corporation</b>	
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>1051 West 26th Place</b>	
13e. ZIP CODE <b>46407</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>Black</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>22</b> College (1-4 or 5+) <b>0</b>					
18. FATHER'S NAME (First, Middle, Last) <b>Winfield Woodard</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Imogene McClellan</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Mildred Woodard</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1051 West 26th Place Gary, Indiana 46407</b>		20c. Relationship <b>Wife</b>	
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) <b>May 11, 2007 Ridgelawn Cemetery</b>			21c. LOCATION—City or Town, State <b>Gary, Indiana</b>		
22a. EMBALMER'S NAME <b>Linda Joyce Hanson</b>				22b. EMBALMER'S LICENSE NO. <b>FD29400049</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Linda Joyce Hanson</i>				24b. LICENSE NUMBER (of Licensee) <b>FD29400049</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Ridgelawn Funeral Home 4201 West Ridge Road Gary, Indiana 46408 FH10200007</b>	
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. <b>Acute Myocardial Infarction</b> b. <b>Coronary atherosclerotic heart disease</b> c. <b>Coronary artery atherosclerosis</b> d. <b>Arteriosclerotic cerebrovascular disease</b> PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <b>Decubitus ulcer Septicemia</b> Approximate Interval Between Onset and Death							
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. <b>IND25043</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/14/07</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>RITA ANNE BOYD (MIM), 8300 BROADWAY, Merrillville, IN 46454</b>							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Boyd</i>						32. DATE FILED (Month, Day, Year) <b>May 16, 2007</b>	
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) <b>JUN 07 2007</b>		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
34d. DESCRIBE HOW INJURY OCCURRED <b>\$11 CS</b>				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) <b>KATONA LAKE COUNTY AUDITOR</b>				34g. DATE PRONOUNCED DEAD (Month, Day, Year)			
34h. MOTOR VEHICLE ACCIDENT? (Yes or no)				34i. <b>021400 CP</b>			