* 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.

Local No. 248

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Nov. 15, 2001 — Date Issued

[signature] — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): William D. Yates

2 SEX: Male

3a TIME OF DEATH: 5:50 PM

3b DATE OF DEATH (Month, Day, Yr): March 11, 2001

4 *SOCIAL SECURITY NUMBER: 587-01-9708

5a AGE—Last Birthday (Years): 54

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo, Day, Yr): August 29,1946

7 BIRTHPLACE (City and State or Foreign Country): Grenada,Mississippi

8a WAS DECEDENT A U.S. VETERAN?: YES

8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1973

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number): St. Margaret's Hospital

9c CITY, TOWN, OR LOCATION OF DEATH: Hammond

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): Switchman

12b KIND OF BUSINESS/INDUSTRY: E J & E Railroad

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 4925 West 9th Avenue

13e ZIP CODE: 46406

13f INSIDE CITY LIMITS: ☐ No XXX Yes

13g ON A FARM?: XX No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: U S A

15 WAS DECEDENT OF HISPANIC ORIGIN? XXX No ☐ 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): 12th; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): John D. Yates

19 MOTHER'S NAME (First, Middle, Maiden Surname): Jessie Kincade

INFORMANT

20a INFORMANT'S NAME (Type/Print): Sharon R. Yates

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4401 East 6th Avenue Gary, Indiana 46403

20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment XXX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 16, 2001 Evergreen Cemetery

21c LOCATION—City or Town, State: Hobart,Indiana

22a EMBALMER'S NAME: Roosevelt Allen Jr.

22b EMBALMER'S LICENSE NO: #01051701

23 WAS DEATH REPORTED TO CORONER? XXX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

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 #30007049

CAUSE OF DEATH

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	CARCINOMA OF LUNG	Few months
b DUE TO (OR AS A CONSEQUENCE OF)	METASTATIC BRAIN DISEASE	Few weeks
c DUE TO (OR AS A CONSEQUENCE OF)		
d DUE TO (OR AS A CONSEQUENCE OF)		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? 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): No

CERTIFIER

29a CERTIFIER (Check only one): XXX CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ 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. ☐ 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: [signature]

29c MEDICAL LICENSE NO: 01031445

29d DATE SIGNED (Month, Day, Year): 4/4/01 April

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. M. Hussain, 8032 Kennedy Avenue Highland, IN. 46322

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Bermuda M.D.

32 DATE FILED (Month, Day, Year): April 6, 2001

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide

34a DATE OF INJURY (Month, Day, Year):

34b TIME OF INJURY:

34c INJURY AT WORK? (Yes or no):

34d DESCRIBE HOW INJURY OCCURRED:

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.

SDH06-004 State Form 10110 (R5/1-99)

Parcel # 25-46-563-3

$11 12376 CS

2007 053349

2007 JUN 29 PM 3:07

MICHAEL A. BROWN RECORDER

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

FILED

20 2007 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR