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City Of East Chicago
East Chicago, In 46312

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. 39

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 85 44-0195-00110

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

85 44-0395 0009

TYPE/PRINT IN PERMANENT BLACK INK

1

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Thurston Haggard
2. SEX: Male
3a. TIME OF DEATH: 10:05 AM
3b. DATE OF DEATH (Month, Day, Yr): February 3, 2007
4. *SOCIAL SECURITY NUMBER: 427-48-0624
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): February 10,1925
7. BIRTHPLACE (City and State or Foreign Country): Bolton, Mississippi
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Regency Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Lavinia Curtis
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Speed Operator
12b. KIND OF BUSINESS/INDUSTRY: LTV Steel Corp.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 1333 Van Buren Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U S A
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ 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): 8th; College (1-4 or 5 +)

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Haggard
19. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice Hill

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Lavinia Haggard
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1333 Van Buren Street Gary,Indiana 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 9, 2007 Oak Hill Cemetery
21c. LOCATION—City or Town, State: Gary,Indiana
22a. EMBALMER'S NAME: ReShanta Nichols
22b. EMBALMER'S LICENSE NO: #20600079
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Valerie Broady
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

2007 061133

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Septic shock
DUE TO (OR AS A CONSEQUENCE OF)
b. Multi organ dysfunction Syndrome.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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: Pneumonia. Decubitus ulcer. CHF. Infiltrative Cardiomyopathy. DM2, IR Advanced Alzheimer's dementia.

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): No

CERTIFIER

29a. CERTIFIER (Check only one)
☑ 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
29c. MEDICAL LICENSE NO: 01046988
29d. DATE SIGNED (Month, Day, Year): 2/9/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Olabode Oladende 5384 Broadway. Merrillville IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paula Bordner Aborinko MD
32. DATE FILED (Month, Day, Year): 2/15/07

FILED

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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
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.

JUL 27 2007
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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(7/05)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT