

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. 04 0123

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Mahalia Castleberry		2 SEX Female	3a TIME OF DEATH 2:00P	3b DATE OF DEATH (Month Day Yr) February 23, 2004
4 *SOCIAL SECURITY NUMBER 310-22-0453	5a AGE—Last Birthday (Years) 90	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) November 1, 1913
7 BIRTHPLACE (City and State or Foreign Country) 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 <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) 4742 West 11th Avenue		9c CITY, TOWN, OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed	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) Homemaker		12b KIND OF BUSINESS/INDUSTRY None
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 4724 West 11th Avenue	
13e ZIP CODE 46406	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
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (9-12) 7 College (1-4 or 5 +) 90		18 FATHER'S NAME (First Middle Last) William Anderson		
19 MOTHER'S NAME (First Middle Maiden Surname) Elizabeth (unknown)		20a INFORMANT'S NAME (Type/Print) Vennie M. Dates		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State ZIP Code) 4724 West 11th Avenue Gary, Indiana 46406		20c Relationship Daughter		
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) March 1, 2004 Fern Oaks Cemetery		21c LOCATION—City or Town State Griffith, 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		24b LICENSE NUMBER (of Licensee) #08700298		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) a Alzheimer Dementia DUE TO (OR AS A CONSEQUENCE OF) b 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				
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 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 R. Hood			29c MEDICAL LICENSE NO. 01036132	29d DATE SIGNED (Month Day Year) 3/1/2004
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Ricardo Hood 4320 Fir Street East Chicago, Indiana 46312				
31 HEALTH OFFICER'S SIGNATURE [Signature]				32 DATE FILED (Month Day Year) MAR 05 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"/> Could not be Determined <input type="checkbox"/> Homicide				
34a DATE OF INJURY (Month Day Year) JUL 10 2007		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED 009135 #11 CS		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		
34g DATE PRONOUNCED DEAD (Month Day Year)			34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.	

DECEDENT

PARENTS

INFORMANT

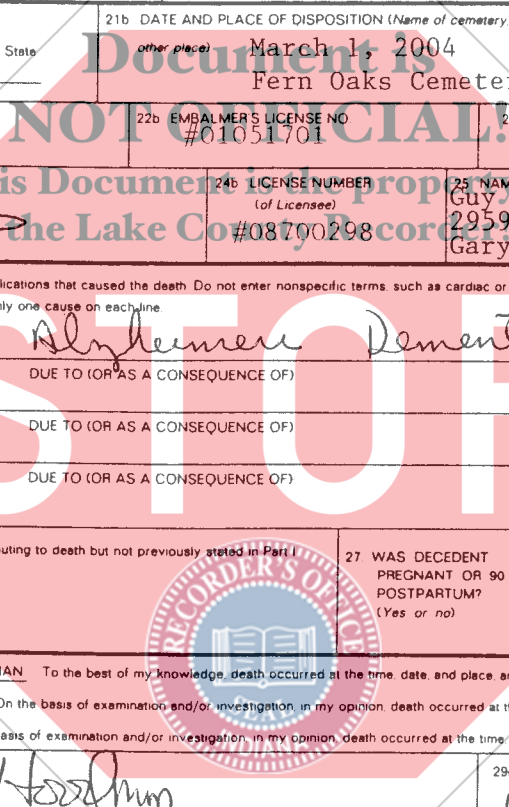
DISPOSITION

CAUSE OF DEATH

25-46-0116-0014
Oakland Realty Co's Sub
5.10ft lot 13, all lot 14
+ N10ft lot 15

CERTIFIER

HEALTH OFFICER



FILED

CRA