

Key # 46-515-3

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to ensure 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. 2352-07

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) Bernice Thompson		2. SEX Female	3a. TIME OF DEATH 11:40pM	3b. DATE OF DEATH (Month, Day, Year) September 16, 2007	
4. *SOCIAL SECURITY NUMBER 414-38-1984	5a. AGE - Last Birthday (Years) 85	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) February 26, 1922	
7. BIRTHPLACE (City and State or Foreign Country) Arkansas		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			
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9b. FACILITY NAME (If not institution, give street and number) Towne Center	9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Early Thompson	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Sales Clerk		12b. KIND OF BUSINESS/INDUSTRY Clothing	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary	13d. STREET AND NUMBER 617 West 19th Place		
13e. ZIP CODE 46407	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/Secondary (0-12) College (1-4 or 5+) 2 years		18. FATHER'S NAME (First, Middle, Last) Jainks Collins Sr.			
19. MOTHER'S NAME (First, Middle, Maiden Surname)		20a. INFORMANT'S NAME (Type/Print) Early Thompson			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 617 West 19th Place Gary, Indiana 46407		20c. Relationship Husband			
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) September 24, 2007 Abraham Lincoln Cemetery		21c. LOCATION - City or Town, State Elwood, Illinois	
22a. EMBALMER'S NAME: Taquia Addison		22b. EMBALMER'S LICENSE NO. #20500009	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> XXXX <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) #20500009	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 #2007704		
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) Failure to Thrive Non-Hodgkin's Lymphoma HIV a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 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 <i>[Signature]</i>			29c. MEDICAL LICENSE NO. 02002106	29d. DATE SIGNED (Month, Day, Year) 09/20/07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Kupesh J. Shan 202E 86th Pl. Merrillville, IN 46411					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) October 2, 2007		
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) DEC 14 2007	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or No)	34d. DESCRIBE HOW INJURY OCCURRED \$11 CS CPX
34e. PLACE OF INJURY (At home, farm, etc.; factory, office building, etc. (Specify) PEGGY I LAKE C... NA		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 024507			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) LAKE C... 34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.					