

* 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.

25-46-0256-0005

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) Early Caldwell Jr.		2. SEX Male	3a. TIME OF DEATH 8:30 P M	3b. DATE OF DEATH (Month, Day, Year) November 14, 2007
4. SOCIAL SECURITY NUMBER 726-05-5112	5a. AGE - Last Birthday (Years) 88	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) April 19, 1919
7. BIRTHPLACE (City and State or Foreign Country) Tennessee	8a. WAS DECEDENT A U.S. VETERAN? YES			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		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) Timberview Nursing Home		9c. CITY, TOWN, OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Celestine Carney	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Machinist		12b. KIND OF BUSINESS/INDUSTRY USX Steel (Coke Plant)
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 1536 Rutledge Street
13e. ZIP CODE 46404	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+) 4 years		18. FATHER'S NAME (First, Middle, Last) Early Caldwell Sr.		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Williams			20a. INFORMANT'S NAME (Type/Print) Celestine Caldwell	
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 1536 Rutledge Street Gary, Indiana 46404		20c. Relationship Wife		
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) November 24, 2007 Oak Hill Cemetery		21c. LOCATION - City or Town, State Gary, Indiana
22a. EMBALMER'S NAME: Rosenwald D. Allen Jr.		22b. EMBALMER'S LICENSE NO. #29400047	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input 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. Cerebrovascular accident b. arterial sclerosis cerebrovascular c. Advanced age / senility d. Severe degenerative arthritis PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. 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) -----	
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		29c. MEDICAL LICENSE NO. IND 25043	29d. DATE SIGNED (Month, Day, Year) 11/19/07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) PEGGY HOLINGA KATONA 8300 BROADWAY MERRILLVILLE IN 46404				
31. HEALTH OFFICER'S SIGNATURE		32. DATE FILED (Month, Day, Year) NOV 21 2007		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could Not Be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or No)
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) 25024		34e. DESCRIBE INJURY OCCURRED DEC 11 2007		
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) LAKE COUNTY AUDITOR		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify (Type of Motor Vehicle, Make, Model, etc.)				