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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. 862

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE / COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.
Date Issued 11/6/97
Franklin J. Orremunda
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Arthur Waters		2. SEX Male	3a. TIME OF DEATH 11:49 P M	3b. DATE OF DEATH (Month, Day, Yr.) October 23, 1997		
4. *SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE—Last Birthday (Years) 69	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) April 24, 1928	7. BIRTHPLACE (City and State or Foreign Country) New Madrid, Missouri	
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) Intensiva Hospital 5454 Hohman Avenue		9c. CITY, TOWN OR LOCATION OF DEATH Hammond		9d. COUNTY OF DEATH 2000 Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Dorothy Bryan		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pressor		12b. KIND OF BUSINESS/INDUSTRY Vogue Cleaners	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Gary		13d. STREET AND NUMBER 1327 Morton Street	
13a. 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) Afro-Amer.	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (11-4 or 5+)	
18. FATHER'S NAME (First, Middle, Last) Hadie Waters			19. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Cook			
20a. INFORMANT'S NAME (Type/Print) Dorothy Waters		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Morton St. - Gary, IN 46404		20c. Relationship Wife		
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) Saturday, Nov. 1, 1997 Evergreen Memorial Park		21c. LOCATION (City or Town, State) Hobart, Indiana		
22a. EMBALMER'S NAME Sherman Banks III		22b. EMBALMER'S LICENSE NO. FDO 1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Sherman Banks III</i>		24b. LICENSE NUMBER (of Licensee) FDO 1016254		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell Warner & Son Funeral Home FH196000 4209 Grant St. - Gary, IN 46408		
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. <i>Cachexia</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>sever malnutrition</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>sever generalized vasculardisease</i> DUE TO (OR AS A CONSEQUENCE OF) d. PART II - Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>My parents on End stage renal disease</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) 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. 01030716		29d. DATE SIGNED (Month, Day, Year) 11/6/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Ali Kheirbek, 5454 Hohman Avenue, Hammond, IN 46324 932-2300		32. DATE FILED (Month, Day, Year) (Nov.) November 6, 1997				
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Orremunda M.D.</i>		32. DATE FILED (Month, Day, Year) November 6, 1997				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) DEC 14 2007	34b. TIME OF INJURY FILED	34c. INJURY AT WORK? or		34d. DESCRIBE HOW INJURY OCCURRED 11
34a. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) LAKE COUNTY AUDIT		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 024476				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE INVOLVED? (If yes, specify driver, passenger, pedestrian, etc.) LAKE COUNTY AUDIT		34i. IDENTIFICATION NUMBER 024476		