* **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.

3CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 03 0 [illegible]

State No. 25-44-0135-0030

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
Wade	Buggs Sr.	Male	6:00 A M	March 15, 2003

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR (Months / Days)	5c UNDER 1 DAY (Hours / Minutes)	6 DATE OF BIRTH (Mo. Day, Yr.)	7 BIRTHPLACE (City and State or Foreign Country)
314-26-5434	2003 071	004579		September 27, 1931	Hulka, Mississippi

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital Northlake	Gary	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Arletha Perkins	Teamleader	U S Steel Corp.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	810 Lincoln Street

13e ZIP CODE	13f INSIDE CITY LIMITS	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
					Elementary/Secondary (0-12)	College (1-4 or 5 +)
46402	13g ON A FARM? XX No ☐ Yes	U S A	XX No ☐ Yes	Black	10th	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Robert Calvin Buggs	Tina Fitzpatrick

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Arletha Buggs	810 Lincoln Street Gary, Indiana 46402	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	March 20, 2003 Fern Oaks Cemetery	Griffith, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
Rosenwald D. Allen Jr.	#29400047	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	#08700646	Guy C. Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Metastatic Cancer of the Lung — Approximate Interval Between Onset and Death: 5 months

Conditions if any, which gave rise to the immediate cause, stating the underlying cause last:
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: Cancer Roma of the prostate

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
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.	29d DATE SIGNED (Month, Day, Year)
Barbara L. Fuller, MD	01034701	4/8/03

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Barbara L. Fuller, MD. 801 MacArthur Blvd. Ste. 401 Munster, IN 46321

EALTH FFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
[signature] (MD, 04/7/11)	APR 9 2003

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c [illegible] WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
XX Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	34f LOCATION (Street and 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.

FILED
JAN 18 2008
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

04331

11:00 AS

SDH06-004 State Form 10110 (R5/1-99)