Re-Sub

* **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

Local No. 99-0785 State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Johnie Moore Sr.

2 SEX: Male

3a TIME OF DEATH: 9:35 P M

3b DATE OF DEATH (Month Day Yr): November 10, 1999

4 *SOCIAL SECURITY NUMBER: 491-16-0389

5a AGE—Last Birthday (Years): 86

5b UNDER 1 YEAR Months Days:

5c UNDER 1 DAY Hours Minutes:

6 DATE OF BIRTH (Mo Day Yr): April 1, 1913

7 BIRTHPLACE (City and State or Foreign Country): Maryann, Arkansas

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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XXX Residence

9b FACILITY NAME (If not institution give street and number): 3172 West 19th Place

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): Ozie T. Moore

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Pipefitter

12b KIND OF BUSINESS/INDUSTRY: American Bridge

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Gary

13d STREET AND NUMBER: 3172 West 19th Place

13e ZIP CODE: 46404

13f INSIDE CITY LIMITS ☐ No XXX Yes

13g ON A FARM? XXX ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: U S A

15 WAS DECEDENT OF HISPANIC ORIGIN? XXX ☐ 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): 12th; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First Middle Last): James S. Moore

19 MOTHER'S NAME (First Middle Maiden Surname): Eliza Scafie

INFORMANT

20a INFORMANT'S NAME (Type/Print): Ozie T. Moore

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 3172 West 19th Place Gary, Indiana 46404

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: XXX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): November 15, 1999 Evergreen Cemetery

21c LOCATION—City or Town State: Hobart, Indiana

22a EMBALMER'S NAME: Rosenwald D. Allen Jr.

22b EMBALMER'S LICENSE NO: #29400047

23 WAS DEATH REPORTED TO CORONER? XXX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR

24b LICENSE NUMBER (of Licensed): #08700298

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 #83007704

USE OF ATH

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 Carcinoma of Prostate

Approximate Interval Between Onset and Death

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

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)

IFIER

29a CERTIFIER (Check only one): XXX 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: David E. Ross MD

29c MEDICAL LICENSE NO: #01018989

29d DATE SIGNED (Month Day Year): 12-13-99

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. David E. Ross Jr. MD 1619 West 5th Avenue Gary, Indiana 46404

TH ER

31 HEALTH OFFICER'S SIGNATURE

32 DATE FILED (Month Day Year): DEC 13 1999

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide

34a DATE OF INJURY (Month Day Year)

34b TIME OF INJURY

34c INJURY AT WORK? (Yes or no)

34d DESCRIBE HOW INJURY OCCURRED

34e PLACE OF INJURY—At home farm street factory office building etc (Specify)

34f LOCATION (Street and Number or Rural Route Number City or Town State): 3520

34g DATE PRONOUNCED DEAD (Month Day Year)

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1