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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.

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No. 24-30-0433-0012

Local No. 6

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) Trevillion Williams, Sr.		2. SEX Male	3a. TIME OF DEATH 10:50P.-M	3b. DATE OF DEATH (Month, Day, Yr.) January 4, 2006
4. *SOCIAL SECURITY NUMBER 426-28-5537	5a. AGE—Last Birthday (Years) 83	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) September 9, 1922
7. BIRTHPLACE (City and State or Foreign Country) Red Lick, Mississippi				
9a. PLACE OF DEATH (Check only one. See instructions)				
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	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) St. Catherine Hospital		9c. CITY, TOWN, OR LOCATION OF DEATH East Chicago		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Amanda Tillmon	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Laborer (retired)		12b. KIND OF BUSINESS/INDUSTRY Universal Atlas Cement
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION East Chicago		13d. STREET AND NUMBER 4721 Kennedy Avenue
13e. ZIP CODE 46312	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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)		17. DECEDENT'S EDUCATION (Specify only highest grade completed)		
Elementary/Secondary (0-12) 10th		College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) Robert Williams		19. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Wesley		
20a. INFORMANT'S NAME (Type/Print) Trevillion Williams, Jr		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4721 Kennedy Ave. East Chicago, IN 46312		20c. Relationship Son
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) January 12, 2006 Concordia Cemetery		21c. LOCATION—City or Town, State Hammond, Indiana
22a. EMBALMER'S NAME Tracy Cheri Williams		22b. EMBALMER'S LICENSE NO. FDO8600238		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Tracy Cheri Williams</i>		24b. LICENSE NUMBER (of Licensee) FDO8600238		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Hinton & Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, IN 46312 FH83001520
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>Route MI</i> DUE TO (OR AS A CONSEQUENCE OF)				
b. <i>Permanency artery disease</i> DUE TO (OR AS A CONSEQUENCE OF)				
c. <i>Hypertension</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.				
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 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. 01038128A		29d. DATE SIGNED (Month, Day, Year) 1-10-06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Ramon P Lobet 7217 Indianapolis Blvd Hammond, IN 46324				
31. HEALTH OFFICER'S SIGNATURE				32. DATE FILED (Month, Day, Year) 1/10/06
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) 6037
34d. DESCRIPTION OF INJURY OR DISEASE		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) PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. → TRYAN				



INDIANA (589) SDH06-004 State Form 10110 (R5/1-99)

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT



STATE OF INDIANA
LAKE COUNTY
FILED
JAN 10 2006
AM 9:17
BROWN

FILED
MAR 12 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR



OFFICE OF THE LAKE COUNTY RECORDER

LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, INDIANA 46307

MICHAEL A. BROWN
Recorder

PHONE (219) 755-3730
FAX (219) 755-3257

MEMORANDUM

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CUSTOMER INITIALS IR DATE: / /

EMPLOYEE INITIALS RM DATE: 3/12/08