12 + 3 Vets

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 96-0119

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 2546-0510-2025

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): Harold W Taylor JR
2. SEX: Male
3a. TIME OF DEATH: 11:12PM
3b. DATE OF DEATH (Month Day Yr): February 13, 1996
4. SOCIAL SECURITY NUMBER: 409-50-8722
5a. AGE - Last Birthday (Years): 64
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo Day Yr): Jan 11, 1932
7. BIRTHPLACE (City and State or Foreign Country): Cuba, TN
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1955
9a. PLACE OF DEATH (Check only one. See instructions): [X] HOSPITAL Inpatient; [ ] ER/Outpatient; [ ] DOA; [ ] OTHER Nursing Home; [ ] Residence; [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Northlake
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): Bernice Agnes Congress
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steel Worker
12b. KIND OF BUSINESS INDUSTRY: Manufacturing
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 2037 Ohio Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Harold Taylor
19. MOTHER'S NAME (First, Middle, Maiden Surname): Margie Vandiver

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Bernice Agnes Taylor
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2037 Ohio Street, Gary, IN 46407
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment; [X] Burial; [ ] Cremation; [ ] Removal from State; [ ] Donation; [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Feb 17, 1996 Evergreen Memorial
21c. LOCATION - City or Town State: Hobart, IN
22a. EMBALMER'S NAME: Sherman G. Banks
22b. EMBALMER'S LICENSE NO.: FDE1016254
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO1042607
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH88900011 Smith Bizzell & Warner 4209 Grant Street, Gary, IN 46408

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. Cardiorespiratory arrest — DUE TO (OR AS A CONSEQUENCE OF)
b. Carcinoma Lung — DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any which gave rise to the immediate cause stating the underlying cause last
c. _____ — DUE TO (OR AS A CONSEQUENCE OF)
d. _____

Approximate Interval Between Onset and Death

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

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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: [signature] Dr H Macabalitaw MD
29c. MEDICAL LICENSE NO: 01041978
29d. DATE SIGNED (Month Day Year): 2-20-96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr H Macabalitaw, 1619 West 5th Avenue, Gary, IN 46404

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month Day Year): FEB 20 1996

FILED

33. MANNER OF DEATH: [ ] Natural; [ ] Accident; [ ] Suicide; [ ] Homicide; [ ] Pending Investigation; [ ] Could not be Determined
34a. DATE OF INJURY (Month Day Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no): 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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.: No

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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCERIP-1