

Key#

45-08-16-303-018.000-004

7CC + 3 Free vETS

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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.

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) Zeb Green Jr.		2 SEX Male	3a TIME OF DEATH 9:20p.m.	3b DATE OF DEATH (Month Day Yr.) October 10, 2003
4 *SOCIAL SECURITY NUMBER 426-32-9624		5a AGE—Last Birthday (Years) 79	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day Yr.) November 12, 1923		7 BIRTHPLACE (City and State or Foreign Country) Canton, Mississippi		
8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	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) Methodist Hospital Northlake		9c CITY, TOWN, OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Lena Mae Gibbs	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Welder		12b KIND OF BUSINESS/INDUSTRY Budd Company
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary	13d STREET AND NUMBER 2528 Buchanan Street	
13e ZIP CODE 46407	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input 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) Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 9th		18 FATHER'S NAME (First, Middle, Last) Zeb Green Sr.		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Angie Bell Grant		20a INFORMANT'S NAME (Type/Print) Lena Mae Green		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2528 Buchanan Street Gary, Indiana 46407		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) October 17, 2003 Oak Hill Cemetery		21c LOCATION—City or Town, State Gary, Indiana
22a EMBALMER'S NAME Roosevelt Allen Jr.		22b EMBALMER'S LICENSE NO. #01051701	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Valerie Broad</i>		24b LICENSE NUMBER (of License) #08800646	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 2059 West 11th Avenue Gary, Indiana 46404 #83007704	
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 WITH METASTASIS DUE TO (OR AS A CONSEQUENCE OF) b OBSTRUCTIVE UROPATHY c ALZHEIMER'S DISEASE 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 AT TIME OF DEATH? (Yes or no) NO		28a WAS A NATAL DEATH? (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>Steven Okam</i>			29c MEDICAL LICENSE NO. 01056232	29d DATE SIGNED (Month Day Year) 10 21 2003
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. MARY O. OKAM-UBANWA 3195 Broadway Gary, IN 46409				
31 HEALTH OFFICER'S SIGNATURE <i>Mary Okam</i>				32 DATE FILED (Month Day Year) OCT 22 2003
33 MANNER OF DEATH <input checked="" 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)
34d DESCRIBE HOW INJURY OCCURRED CS		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) 014803 11
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		

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