



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-08-05-479-000.000.004

Local No. 08 0305

State No.

| | | | | | | | | | | |
|---|---|---|---|---|---|--|--|--|---|--|
| 1. Decedent's Legal Name (First, Middle, Last) JAMES TILLIS BURROUGHS | | | | 1a. Maiden Last Name (If Female) | | 2. Sex MALE | 3. Time Of Death 3:40 am | 4. Date Of Death (Month/Day/Year) MAY 29, 2008 | | |
| 5. Social Security Number 424405028 | | 6a. Age - Yrs 73 | 6b. Under 1 Year | 6c. Under 1 Month | 6d. Under 1 Day | 6e. Under 1 Hour | 7. Date Of Birth (Month/Day/Year) MAR. 2, 1935 | | 8. Birthplace (City And State Or Foreign Country) NEW BROCKTON, ALABAMA | |
| 9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival | | | | 10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify) | | | | |
| 11. Facility Name (If Not Institution, Give Street And Number) METHODIST HOSPITAL NORTHLAKE | | | | | | | | | | |
| 12. City Or Town, State, And Zip Code GARY, INDIANA | | | | | 13. County Of Death LAKE | | 14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | | |
| 15. Surviving Spouse's Name BEULAH BURROUGHS | | | 15a. (If Wife) Give Maiden Last Name BARNES | | 16. Decedent's Usual Occupation DRIVER | | 17. Kind Of Business/Industry ELKA DAYCARE | | | |
| 18. Residence - State INDIANA | | | 18a. County LAKE | | 18b. City Or Town GARY | | 18c. Street And Number 750 GARFIELD STREET | 18d. Apt. No. | 18e. Zip Code 46404 | |
| 18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 19. Decedent's Education 6th GRADE | 20. Decedent Of Hispanic Origin NO | | 21. Decedent's Race AFRICAN AMERICAN | | | | 22. Father's Name (First, Middle, Last) ALFRED BURROUGHS | 23. Mother's Name (First, Middle, Last) FLOSSIE COLE | |
| 23a. Mother's Maiden Last Name COLE | 24. Informant's Name BUELAH BURROUGHS | | | 24a. Relationship To Decedent WIFE | 24b. Mailing Address (Street And Number, City, State, Zip Code) 750 GARFIELD ST GARY, INDIANA 46404 | | | | | |
| 25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify) | | 25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) OAK HILL CEMETERY | | | 25c. Location - City, Town, And State GARY, INDIANA | | | | | |
| 26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 27. Name And Complete Address Of Funeral Facility HOUSE OF ROBINSON FUNERAL DIRECTORS 1900 West 15th Avenue Gary, Indiana 46404 | | | | | | 27a. Funeral Home License Number: FH19500007 | | | |
| 27b. Signature Of Indiana Funeral Service Licensee: <i>Paul Anthony [Signature]</i> | | | | | | 27c. License Number (Of Licensee): 1017284 | | | | |
| 28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death, Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death): A. Pneumonia B. Dementia C. D. Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last | | | | | | | | | | |
| 28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I | | | | | | | | | | |
| 29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown <input type="checkbox"/> Pregnant Within The Past Year | | | | 33. Manner Of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined | | | | |
| 34. Date Of Injury (Month/Day/Year) | | 35. Time Of Injury | | 36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area) | | | 37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 38. Location Of Injury - State | | 38a. City Or Town | | 38b. Street & Number | | 38c. Apt. No. | 38d. Zip Code | | | |
| 39. Describe How Injury Occurred | | | | | | 40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) \$11 CS [Signature] | | | | |
| 41. Signature, Of Person Certifying Cause Of Death <i>[Signature]</i> | | | | | | 42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer | | | | |
| 43. Name, Address And Zip Code Of Person Certifying Cause Of Death: PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR 015605 | | | | | | 44. License Number 01052287 | | 45. Date Certified 6/2-08 | | |
| 46. Additional Funeral Service Provider: | | | | | | 47. *Akas: | | | | |
| 48. Signature of Local Health Officer: <i>[Signature]</i> | | | | | | 49. For Registrar Only - Date Filed (Month/Day/Year): JUN 04 2008 | | | | |