This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

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): Cecil Ross
2. SEX: Male
3a. TIME OF DEATH: 2:40 P.M M
3b. DATE OF DEATH (Month, Day, Yr.): November 27, 2000
4. SOCIAL SECURITY NUMBER: 311-07-0769
5a. AGE--Last Birthday (Years): 88
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): June 24, 1912
7. BIRTHPLACE (City and State or Foreign Country): Jeffersonville, Indiana
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) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Valporaiso Care & Rehabilitation
9c. CITY, TOWN, OR LOCATION OF DEATH: Valporaiso
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Irene Sanders
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): U.S. Steel Mill
12b. KIND OF BUSINESS/INDUSTRY: Steel Mill
13a. RESIDENCE--STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 727 Mississippi Street
13e. ZIP CODE: 46402
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Harry Ross
19. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret (Unavailable)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Irene Ross
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 727 Mississippi Gary, Indiana 46402
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 02, 2000 Evergreen Memorial Park
21c. LOCATION--City or Town, State: Hobart, IN
22a. EMBALMER'S NAME: Sherman Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature] Sherman Banks
24b. LICENSE NUMBER (of Licensee): FD 01016254
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home. FH19600034 4209 Grant St, 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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Respiratory Insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
c. Cerebro-Vascular Accident (CVA)
DUE TO (OR AS A CONSEQUENCE OF):
d. Malnutrition - Dehydration

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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)
☒ 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] G. F. Badar
29c. MEDICAL LICENSE NO.: 01026783
29d. DATE SIGNED (Month, Day, Year): [illegible]
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): G F Badar, MD, 5490 Broadway, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): DECEMBER 13, 2000

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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT (Yes or no) If yes specify driver, passenger, pedestrian, etc.

$11

018410

2008 075 5

FILED NOV 03 2008 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1