Local No. 415-88

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

45-08-87-153-005-000004

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME FIRST: WILLIE MIDDLE: L. LAST: HARE SR.
2. SEX: MALE
3. DATE OF DEATH (Mo., Day, Yr.): FEBRUARY 13, 19[illegible]
4. SOCIAL SECURITY NUMBER: 428-18-8242
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Month, Day, Year): 11-17-1917
7. BIRTHPLACE (City and State or Foreign Country): ALABAMA
8. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): METHODIST HOSPITAL SOUTHLAKE
9c. CITY, TOWN OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): ROSA E. HARE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RETIRED OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: U.S.X. CORP.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 4305 West 11th Avenue
13e. INSIDE CITY LIMITS? (Yes or no): yes
13f. FARM: no
13g. ZIP CODE: 46404
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): Black
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last): JOSH HARE
18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE

INFORMANT

19a. INFORMANT'S NAME (Type/Print): ROSA E. HARE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4305 West 11th Avenue, Gary, IN
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEb. 18, 1988 Evergreen Cemetery
20c. LOCATION—City or Town, State: Hobart, IN
21a. SIGNATURE OF FUNERAL DIRECTOR: Patricia Owens
21b. LICENSE NUMBER (of Licensee): 8700298
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Guy & Allen Funeral Directors, Inc. 2959 West 11th Ave. #F007764

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: M
25. DATE PRONOUNCED DEAD (Month, Day, Year)
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Metastatic lung cancer to liver

DUE TO (OR AS A CONSEQUENCE OF): b.

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

DEC 02 2009

FILED
DEC 07 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
[ ] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] 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) and manner as stated.

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29b. SIGNATURE AND TITLE OF CERTIFIER: P.J. Tara M.D.
29c. LICENSE NUMBER: 1031667
29d. DATE SIGNED (Month, Day, Year): 2/17/88
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): P.J. TARA 8127 MERRILLVILLE ROAD, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): FEB 26, 88

CORONER OR MEDICAL EXAMINER USE ONLY

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)

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD:

Deceased

11w CS Rm