



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

45-68-05-252-626-000-004

Local No. 3023-10

State No.

1. Decedent's Legal Name (First, Middle, Last) Benjamin Harrison Davis				1a. Maiden Last Name (if Female) N/A		2. Sex Male	3. Time Of Death 6:16 am	4. Date Of Death (Month/Day/Year) October 9, 2010	
5. Social Security Number 416-58-1420		6a. Age - Yrs 64		6b. Under 1 Year Months: Days: Hours: Minutes:		7. Date Of Birth (Month/Day/Year) December 25, 1945		8. Birthplace (City And State Or Foreign Country) Birmingham, 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) Community, Hospital									
12. City Or Town, State, And Zip Code Munster, 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 Sharron J. Fuller-Davis			15a. (If Wife) Give Maiden Last Name Fuller		16. Decedent's Usual Occupation RC Operator		17. Kind Of Business/Industry Arcelor Mittal		
18. Residence - State Indiana		18a. County Lake		18b. City Or Town Gary					
18c. Street And Number 360 Roosevelt Street						18d. Apt. No. N/A	18e. Zip Code 46404	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education 1 year College			20. Decedent Of Hispanic Origin No		21. Decedent's Race Black				
22. Father's Name (First, Middle, Last) Thomas Davis				23. Mother's Name (First, Middle, Last) Mary Davis		23a. Mother's Maiden Last Name Wilson			
24. Informant's Name Sharron J. Fuller - Davis		24a. Relationship To Decedent Wife		24b. Mailing Address (Street And Number, City, State, Zip Code) 360 Roosevelt Street Gary, Indiana 46404					
25. Place Of Disposition									
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) October 16, 2010 Evergreen Cemetery			25c. Location - City, Town, And State Hobart, Indiana				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility Guy & Allen Funeral Directors Inc. 2959 W 11th Avenue Gary, Indiana 46404					27a. Funeral Home License Number 83007704		
27b. Signature Of Indiana Funeral Service Licensee: <i>Valerie Brown</i>					27c. License Number (Of Licensee): #08700546				
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. <u>Non-small lung cancer</u> B. <u>Extensive small cell lung cancer</u> C. _____ D. _____ Due To (Or As A Consequence Of): Approximate Interval: Onset To Death <u>2.5 months</u> <u>3.5 months</u>									
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 checked="" 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"/> 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"/> Pregnant Within The Past Year			33. Manner Of Death <input checked="" 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. Location (E.G.: Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input 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) CS			
41. Signature Of Person Certifying Cause Of Death: <i>Barbara L Fuller, M.D.</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 <i>Barbara L Fuller, M.D. 1000 So. Lake Park Ave Ste 1101 Hobart, IN 46342</i>				44. License Number 01034701		45. Date Certified 10/12/2010			
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature Of Local Health Officer: <i>Susan W Best DO</i>						49. For Registrar Only - Date Filed (Month/Day/Year) October 15, 2010			

FILED

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PEGGY HOLINGA-KATONA
LAKE COUNTY AUDITOR

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