18cc + 2 Vets

* 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. 01-0200

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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): Gunnar Lee Hayes
2. SEX: Male
3a. TIME OF DEATH: 9:24 A.M
3b. DATE OF DEATH (Month, Day, Yr.): March 29, 2001
4. *SOCIAL SECURITY NUMBER: 378-24-5953
5a. AGE–Last Birthday (Years): 69
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): May 04, 1931
7. BIRTHPLACE (City and State or Foreign Country): Farwell, Arkansas
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1954
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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 (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Charlene Ewing
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Supervisor
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE–STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 8460 Lakewood Avenue
13e. ZIP CODE: 46403
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): ; College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): (Unavailable)
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie L. Bigsby

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Charlene Hayes
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8460 Lakewood Avenue Gary, Indiana 46403
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): April 03, 2001 Oak Hill Crematory
21c. LOCATION–City or Town, State: Gary, IN
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☑ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Yolanda Lawdurus-Smith
24b. LICENSE NUMBER (of Licensee): FD20000361
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. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
b. Atrial Flutter
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
d.

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: Nazzal Obaid MD
29c. MEDICAL LICENSE NO.: 01028410
29d. DATE SIGNED (Month, Day, Year): 4-16-01
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): NAZZAL OBAID M.D. 8895 BROADWAY MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): APR 18 2001

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.

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MAY 24 2011

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FILED AUG 18 2011 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

AUG 19 2011 11:57 STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

Parcel # 45-05-33-326-003.000-004