

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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.

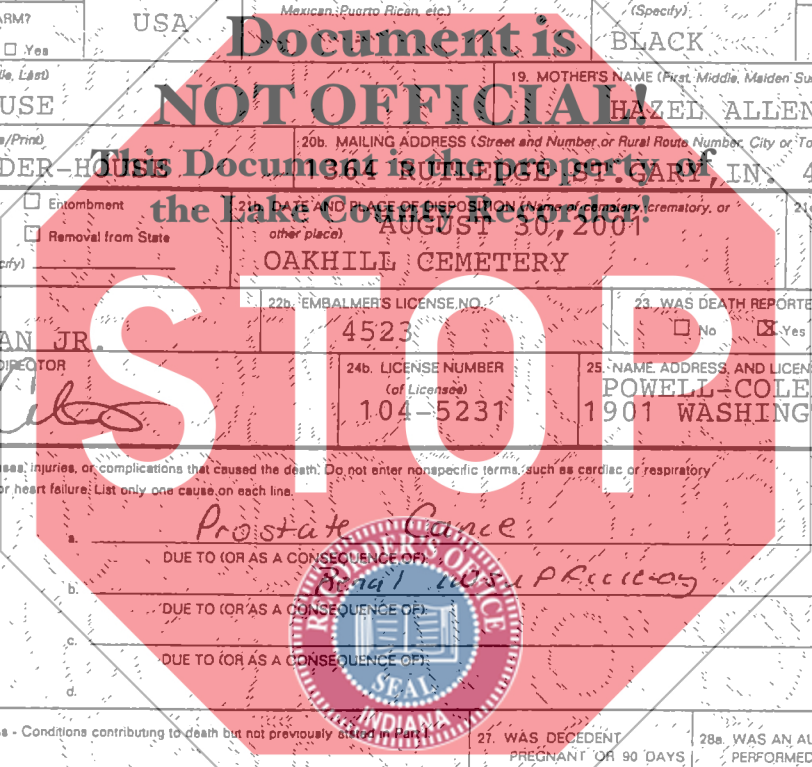
Local No: 01 0553

State No:

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) ARNOLD LEE HOUSE SR.		2. SEX MALE		3a. TIME OF DEATH 7:45a		3b. DATE OF DEATH (Month, Day, Yr.) AUGUST 24, 2001	
4. *SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 68		5b. UNDER 1 YEAR Months: Days:		5c. UNDER 1 DAY Hours: Minutes:	
6. DATE OF BIRTH (Mo, Day, Yr.) NOVEMBER 10 1932		7. BIRTHPLACE (City and State or Foreign Country) CRESCENT, OK.					
8a. WAS DECEDENT A U.S. VETERAN? YES		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1957		9a. PLACE OF DEATH (Check only one: See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) 1364 RUTLEDGE ST.				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) DOVIE BROWDER		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) ENTREPRENEUR		12b. KIND OF BUSINESS/INDUSTRY GENERAL	
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION GARY		13d. STREET AND NUMBER 1364 RUTLEDGE ST.	
13e. ZIP CODE 46404		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12th College (13-16 or 17+)					
18. FATHER'S NAME (First, Middle, Last) WILLIAM HOUSE				19. MOTHER'S NAME (First, Middle, Maiden Surname) HAZEL ALLEN			
20a. INFORMANT'S NAME (Type/Print) DOVIE BROWDER—HUSBAND				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY, IN 46404		20c. Relationship WIFE	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (In case of crematory, or other place) AUGUST 30, 2001 OAKHILL CEMETERY		21c. LOCATION—City or Town, State GARY, IN			
22a. EMBALMERS NAME LEON COLEMAN JR.		22b. EMBALMERS LICENSE NO. 4523		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Leon Coleman Jr.</i>		24b. LICENSE NUMBER (of License) 104-5231		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME POWELL-COLEMAN FUNERAL HOME 1901 WASHINGTON ST. GARY, IN 82602434			
26. PART I: Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Prostate Cancer b. Due to (or as a consequence of) Prostate Cancer c. Due to (or as a consequence of) Prostate Cancer d. Due to (or as a consequence of) Prostate Cancer 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							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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: <i>Cheryl A. Worix</i>				29c. MEDICAL LICENSE NO. 0104840517		29d. DATE SIGNED (Month, Day, Year) 8-29-01	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) CHERYL ANTHONY WORIX, M.D. 919 Marie St. Dyer, Ind.							
31. HEALTH OFFICER'S SIGNATURE: <i>Cheryl A. Worix M.D.</i>						32. DATE FILED (Month, Day, Year) AUG 30 2001	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be Determined		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.							



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

WARNING: ORIGINAL DOCUMENT HAS A MULTICOLORED BACKGROUND ON SPECIAL WHITE SECURITY PAPER AND THE GREAT SEAL OF THE STATE OF INDIANA ON BACK THAT DISAPPEARS FROM ORANGE TO YELLOW WHEN RUBBED. ORIGINAL DOCUMENT HAS HIDDEN VOID ON FRONT THAT APPEARS WHEN PHOTO COPIED.

VOID IF ALTERED OR ERASED

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