

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

Below for State Office Use

- A _____
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- D _____
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- F _____
- G _____
- H _____
- I _____
- J _____
- 1 _____
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Disposition Permit Issued / /

Provisional Certificate
 Yes No

771216
FUNERAL HOME No. 280
FUNERAL DIRECTOR'S No. 783
LICENSE No. # 35-368-1
EMBALMER'S NAME John C. Ault
FUNERAL DIRECTOR'S SIGNATURE [Signature]

Local No. 368

INDIANA STATE BOARD OF HEALTH CORONER'S CERTIFICATE OF DEATH

State No. _____

1. DECEASED—NAME WILLIAM J. ROBERTSON		2. SEX Male	3. DATE OF DEATH (MONTH, DAY, YEAR) August 29, 1984
4. RACE—(a) White, Black, American Indian, etc. (Specify) White	5a. AGE—Last Birthday (Yr.) 56	5b. UNDER 1 YEAR MOS. DAYS	5c. UNDER 1 DAY HOURS MINS.
6. DATE OF BIRTH (Mo., Day, Yr.) 6.11/14/27		7a. COUNTY OF DEATH Lake	
7b. CITY, TOWN OR LOCATION OF DEATH East Chicago		7c. HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number) St. Catherine Hospital	
7d. IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify) E.R.			
8. STATE OF BIRTH (If not in U.S.A. name country) Illinois	9. CITIZEN OF WHAT COUNTRY U.S.A.	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Evelyn Jewell
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) yes			
13. SOCIAL SECURITY NUMBER 306-24-9603		14. KIND OF BUSINESS OR INDUSTRY Indiana Bell Telephone	
15a. RESIDENCE—STATE Indiana		15b. COUNTY Lake	
15c. CITY, TOWN OR LOCATION Hammond		15d. STREET AND NUMBER 6312 Rhode Island	
15e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15f. INSIDE CITY LIMITS (SPECIFY YES OR NO) Yes	
15g. IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16. FATHER—NAME Charles D. Robertson		17. MOTHER—MAIDEN NAME Esther Fitch	
18a. INFORMANT—NAME Evelyn Robertson (Wife)		18b. MAILING ADDRESS 6312 Rhode Island, Hammond, Indiana 46323	
19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		19b. CEMETERY OR CREMATORY—FUNERAL HOME Chapel Lawn Mem. Gardens	
19c. LOCATION Schenerville, Indiana		20a. DATE (MONTH, DAY, YEAR) September 1, 1984	
20b. FUNERAL HOME—NAME AND ADDRESS Bocken Funeral Home, 7042 Kennedy, Hammond, IN 46323			
21a. SIGNATURE [Signature]		21b. DATE SIGNED (Mo., Day, Yr.) 8/31/84	
21c. PRONOUNCED DEAD (Mo., Day, Yr.)		21d. ON 8/29/84	
21e. NAME AND ADDRESS OF CERTIFIER (Type or Print) DANIEL D. THOMAS, M.D., 2293 NORTH MAIN ST., CROWN POINT, IN. 46307			
22a. HEALTH OFFICER—SIGNATURE E. A. Compagnon, M.D.		22b. DATE RECEIVED BY LOCAL HEALTH OFFICER 8-31-84	
23. IMMEDIATE CAUSE Cardiac arrest		Interval between onset and death Undetermined	
23. (b) DUE TO, OR AS A CONSEQUENCE OF Due to severe coronary atherosclerosis; Moderate cardio-		Interval between onset and death	
23. (c) DUE TO OR AS A CONSEQUENCE OF megaly; Hepatomegaly; Splenomegaly		Interval between onset and death	
24. AUTOPSY (Specify Yes or No) Yes			
25a. ACC. SUICIDE, HOMIC. UNDET. OR PENDING INVEST. (Specify) Natural	25b. DATE OF INJURY (Mo., Day, Yr.)	25c. HOUR OF INJURY M	25d. DESCRIBE HOW INJURY OCCURRED
25e. INJURY AT WORK (Specify Yes or No)	25f. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	25g. LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE	

IF DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS.

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE

129

4/00