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LTIC#46323
LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 176-88

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	JAMES M. ROBERTS, JR.
2. SEX	male
3. DATE OF DEATH (Mo. Day, Yr)	January 25, 1988
4. SOCIAL SECURITY NUMBER	312-28-9886
5a. AGE—Last Birthday (Years)	57
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Month, Day, Year)	Oct. 4, 1930
7. BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
8. YEAR LAST SERVED IN US ARMED FORCES?	No
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)	Southlake Methodist Hospital
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)	Barbara Hrischuk
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	Management
12b. KIND OF BUSINESS/INDUSTRY	Anderson Co.-Auto
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Gary
13d. STREET AND NUMBER	4656 Johnson Street
13e. INSIDE CITY LIMITS? (Yes or no)	yes
13f. FARM	no
13g. ZIP CODE	46408
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican etc.) Specify.	[X] No [ ] Yes
15. RACE—American Indian, Black, White, etc. (Specify)	white
16. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): ; College (1-4 or 5+): 3

PARENTS

Field	Entry
17. FATHER'S NAME (First, Middle, Last)	James Roberts, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname)	Mildred Keele

INFORMANT

Field	Entry
19a. INFORMANT'S NAME (Type/Print)	Barbara Roberts
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4656 Johnson Street, Gary, IN 46408
19c. Relationship	spouse

DISPOSITION

Field	Entry
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)	January 28, 1988 Calumet Park Cemetery
20c. LOCATION—City or Town, State	Merrillville, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR	John A. Pruzin (signature)
21b. LICENSE NUMBER (of Licensee)	1007231
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	PRUZIN BROTHERS FUNERAL SERVICE 3002453, 6360 Broadway, Merrillville, Indiana 46410

PRONOUNCING PHYSICIAN ONLY

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

Field	Entry
23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title	R. A. Hovanessian MD
23b. LICENSE NUMBER	01023583
23c. DATE SIGNED (Month, Day, Year)	1/28/88

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

Field	Entry
24. TIME OF DEATH	2:00 AM
25. DATE PRONOUNCED DEAD (Month, Day, Year)	January 25, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)	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. LIVER CIRRHOSIS
DUE TO (OR AS A CONSEQUENCE OF):
b. HEPATIC COMA -
DUE TO (OR AS A CONSEQUENCE OF):
c. Respiratory failure
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

FILED
SEP 23 1988
Anna N. Anton
AUDITOR LAKE COUNTY

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): no

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

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)

[X] 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	R. A. Hovanessian MD
29c. LICENSE NUMBER	01023583
29d. DATE SIGNED (Month, Day, Year)	1/28/88

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Raffy Hovanessian, M.D. 7863 Broadway, Merrillville, Indiana 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Paul A. Johnson MD
32. DATE FILED (Month, Day, Year)	January 28, 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homocide [ ] Pending Investigation [ ] 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)

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LILLIAN A. BLASTICK
RECORDER LAKE COUNTY
CROWN POINT, INDIANA 46307
FILED FOR RECORD
07 AM '88

Rec 47-53-10 LS Indexed Oct Above Pilel Fab 10 2:16 Until 25

SBH06-004 State Form 10110 (R/10-87) CEATH A/PD 1