Rees Funeral Home 600 W. Ridge Rd. Hobart, 46342 ↗ 6 Reg 2 Vet 3 Total

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 907-90 097903

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ROBERT C. SCHARBACH
2. SEX: Male
3a. TIME OF DEATH: 8:00P M
3b. DATE OF DEATH (Month, Day, Yr): April 22, 1990
4. SOCIAL SECURITY NUMBER: 310-03-0264
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): AUG 8, 1912
7. BIRTHPLACE (City and State or Foreign Country): HOBART, INDIANA
8a. WAS DECEDENT A US VETERAN?: Yes
8b. YEAR LAST SERVED IN US ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1205 STATE STREET
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): MARIAN E. ZANDER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): FIELD CLERK
12b. KIND OF BUSINESS/INDUSTRY: TOWNSHIP ASSESSOR
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HOBART
13d. STREET AND NUMBER: 1205 STATE STREET
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): BERNARD SCHARBACH
19. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE MILLER

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARIAN E. SCHARBACH
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1205 STATE STREET, HOBART, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): APR 26, 1990 EVERGREEN MEMORIAL PARK
21c. LOCATION—City or Town, State: HOBART, IN 46342
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO: FDO1004194
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FDH3003069 REES FUNERAL HOME 600 W. OLD RIDGE RD, HOBART, IN 46342

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries or complications that caused the death. Do not enter nonspecific modes of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	CARCINOMATOSIS	weeks
DUE TO (OR AS A CONSEQUENCE OF) b.	CARCINOMA Lung	months
DUE TO (OR AS A CONSEQUENCE OF) c.		
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?: No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

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: A. J. Krsek M.D.
29c. MEDICAL LICENSE NO: 16778
29d. DATE SIGNED (Month, Day, Year): April 24, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): A. KRSEK MD, 10 MICHIGAN AVENUE, HOBART, INDIANA 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): APR 26, 90

CORONER USE ONLY

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) Specify driver, passenger, pedestrian, etc.

FILED APR 30 1990
[signature] AUDITOR LAKE COUNTY

ROBERT ... RECORDER APR 30 3 ... '90 ... LAKE

CERTIFIED COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
APR 26 1990
[signature]
LAKE COUNTY HEALTH COMMISSIONER

Rev# 18-69-12 J. Kramer Sr Add S2 N2 Lot 4 Blk 10 + N½ N½ Lot 4 Blk 10 Ex. N. 30 FT

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

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