6cc

PO Box M 646
Bary 46401

91027923

Local No. 0696-91

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Robert Gaffney Sr.
2 SEX: Male
3a TIME OF DEATH: 6:25a.m.
3b DATE OF DEATH (Month, Day, Yr): March 21, 1991
4 SOCIAL SECURITY NUMBER: 338-38-9402
5a AGE—Last Birthday (Years): 48
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo. Day, Yr): October 23, 1942
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Ill.
8a WAS DECEDENT A U.S. VETERAN? No
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
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): Methodist Hospital Southlake
9c CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Brenda Grant
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Heaterman
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: 631 Martin Luther King Drive
13e ZIP CODE: 46407
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): Black
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Chester Jones
19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Gaffney

INFORMANT

20a INFORMANT'S NAME (Type/Print): Brenda Gaffney
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631 Martin Luther King Drive 46407
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): March 30, 1991 Calumet Park Cemetery
21c LOCATION—City or Town, State: Merrillville, Indiana
22a EMBALMER'S NAME: Roosevelt Allen Sr.
22b EMBALMER'S LICENSE NO.: 01051696
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 08700646
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 8300770 Guy & Allen Funeral Directors, Inc. 2959 W. 11th Ave. Gary, In. 46404

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Metastatic Renal Carcinoma — Approximate Interval Between Onset and Death: > 1 1/2 yr
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
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 resulting in the underlying cause given in Part I: multiple lung & bone metastasis; severe pain; malignant cachexia

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)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
APR 1 1991
[signature] MD
LAKE COUNTY HEALTH COMMISSIONER

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: [signature] MD Dr. Sanghai
29c MEDICAL LICENSE NO.: 01035695B
29d DATE SIGNED (Month, Day, Year): 3. 28. 91
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. SANGHVI 521 East 86th Ave Merrillville IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD
32 DATE FILED (Month, Day, Year): APR 1, 91

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) If yes, specify driver, passenger, pedestrian, etc.

FILED
JUN 6 1991
[signature] Anna N. Anton
RECORDER LAKE COUNTY
00379
600

STATE OF INDIANA S.S.NO. LAKE COUNTY FILED FOR RECORD
91 JUN 6 PM 12 09
ROBERT (BOB) REEENALD RECORDER

Key # 44-34-0 5
Resub. Gary Land Co's. 13th Sub. S. 17 1/2 FT. L.5 Bl.14 N. 22 1/2 FT L.6 Bl.14

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