10cc

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Reg# 50-237-1
East Chicago Land Ass'n Add.
L.1 Bl.14

Local No. 206 State No. ....

91038756

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Robert Oliver Jr
2. SEX: Male
3a. TIME OF DEATH: 9:05 P M
3b. DATE OF DEATH (Month Day Yr): July 18, 1991
4. SOCIAL SECURITY NUMBER: 417-09-5503
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): Feb. 12, 1914
7. BIRTHPLACE (City and State or Foreign Country): Stockton, Alabama
8a. WAS DECEDENT A U.S. 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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Catherine Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife give maiden name): Virginia Bradford
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Operator (retired)
12b. KIND OF BUSINESS/INDUSTRY: Inland Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: East Chicago
13d. STREET AND NUMBER: 4802 McCook Avenue
13e. ZIP CODE: 46312
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): 8th Grade; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Robert Oliver Sr
19. MOTHER'S NAME (First Middle Maiden Surname): Amelia Baker

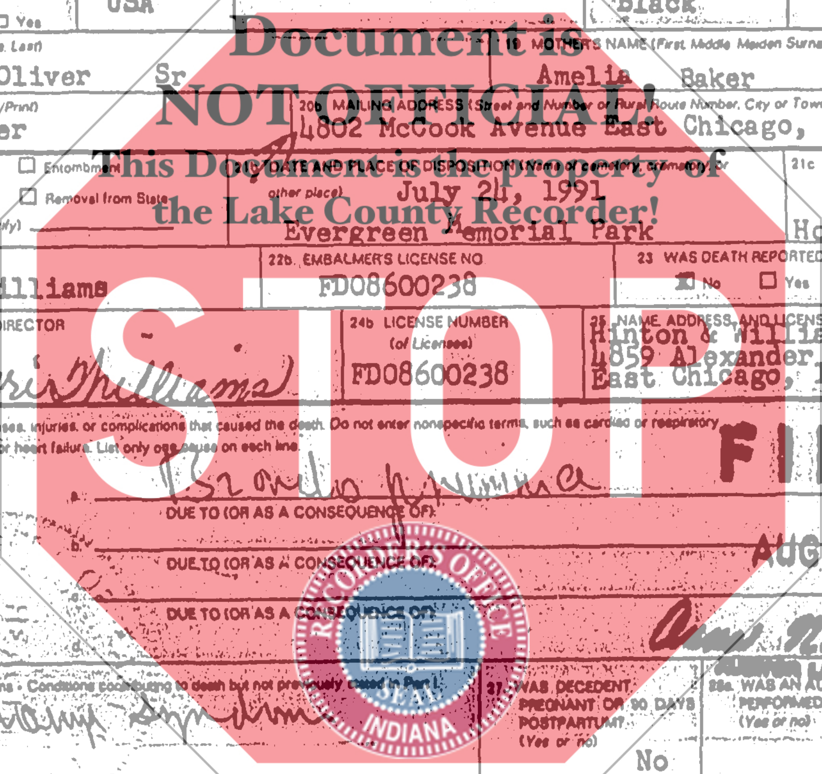
INFORMANT

20a. INFORMANT'S NAME (Type/Print): Virginia Oliver
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4802 McCook Avenue East Chicago, In 46312
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): July 24, 1991 Evergreen Memorial Park
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO.: FD08600238
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Hinton & Williams Funeral Home 4859 Alexander Avenue East Chicago, In 46312 FH83001520

STATE OF INDIANA/S.S. NO. LAKE COUNTY FILED FOR RECORD 3 11 PM '91 ROBERT (BOB) REER RECORDER



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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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Bronchopneumonia
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.

FILED AUG 01 1991 [signature] LAKE COUNTY AUDITOR

PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I: Brain Stem Syndrome
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): ------

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: ELC Broomes MD
29c. MEDICAL LICENSE NO.: 14722
29d. DATE SIGNED (Month, Day, Year): 7-19-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): E.LC. BROOMES, M.D. 2400 Broadway East Chicago, In. 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr. Jeni Rajkovich
32. DATE FILED (Month, Day, Year): 7-22-91

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.

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

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