INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1024-91 91054300

State No. [illegible]

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
ROBERT W. SIMONS	Male	6:09 p M	May 11, 1991

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR (Months / Days)	5c UNDER 1 DAY (Hours / Minutes)	6 DATE OF BIRTH (Mo. Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
308-18-8982	71			October 5, 1919	Russellville, Illinois

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
Yes	1945	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Methodist Hospital - Southlake Campus	Merrillville	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Esther Chasey	Office Manager	Construction

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	4455 Monroe Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
46408	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A	☒ No ☐ Yes	White	12 /

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Robert S. Simons	Mary F. Sanders

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Esther Simons	4455 Monroe Street, Gary, IN 46408	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 15, 1991 Calumet Park Cemetery	Merrillville, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
William D. Smith	9000049	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1009893	PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410

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.	Metastatic Lung Cancer	6 Months
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 OCT 28 1991

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

Emphysema

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28. WAS AUTOPSY PERFORMED? (Yes or no)	29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Barbara L. Fuller M.D.	01034701	5/14/91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Barbara L. Fuller, M.D., 3229 Broadway, Gary, Indiana 46409 980-7160

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE Alexander S. Williams, M.D.

I CERTIFY THAT THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

31a. DATE FILED (Month, Day, Year) 11 Nov 14 1991

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				MAY 14 1991

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.

LAKE COUNTY HEALTH COMMISSIONER

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

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