THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Franklin D. Fernandez

Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1 94002500

CERTIFICATE OF DEATH

St. Date Issued 04/12/1993

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Robert W. Duncanson
2. SEX: Male
3a. TIME OF DEATH: 1:58 PM
3b. DATE OF DEATH (Month, Day, Yr.): January 4, 1993
4. SOCIAL SECURITY NUMBER: 314-20-0694
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr.): May 24, 1927
7. BIRTHPLACE (City and State or Foreign Country): Wheaton, Illinois
8a. WAS DECEDENT A U.S. VETERAN?: yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1947
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): St. Margaret Mercy Hospital North
9c. CITY, TOWN OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): divorced
11. SURVIVING SPOUSE (If wife, give maiden name): none
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Truck Driver
12b. KIND OF BUSINESS/INDUSTRY: City of Hammond
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 550 Florence Street
13e. ZIP CODE: 46324
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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Charles Duncanson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Kestle

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sandra Duncanson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7105 Harrison Ave., Hammond, Indiana 46324
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 8, 1993 Calumeter Park Crematory
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO.: # 1042372
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan
24b. LICENSE NUMBER (of Licensee): FD# 1051840
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Solan Funeral Home FH# 83002893, 7109 Calumet Ave., Hammond, Ind. 46342

CAUSE OF DEATH

26. PART I. Enter the disease, 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. Vascular collapse — Approximate Interval Between Onset and Death: Unknown

DUE TO (OR AS A CONSEQUENCE OF): b. Due to arteriosclerotic heart and vascular disease

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

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? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: Daniel D. Thomas
29c. MEDICAL LICENSE NO.: 16120
29d. DATE SIGNED (Month, Day, Year): January 5, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Fernandez M.D.
32. DATE FILED (Month, Day, Year): January 7, 1993

CORONER USE ONLY

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year): January 4, 1993
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

0488

SDH06 004 State Form 10110 (R3 / 3-92) DEATHCER PD R

Mary I. Duncanson 7149 Harrison Ave. Ham. 46324

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