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Kathy Stupar

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 0950-91 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Robert Lee Davidson, Sr.
2. SEX: Male
3a. TIME OF DEATH: 4:47pm M
3b. DATE OF DEATH (Month Day Yr): April 26, 1991
4. SOCIAL SECURITY NUMBER: 565-14-0745
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr): June 21, 1916
7. BIRTHPLACE (City and State or Foreign Country): Rochester, Indiana
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1957
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): Our Lady Of Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Reba Wilson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pipefitter
12b. KIND OF BUSINESS/INDUSTRY: Local #597
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Cedar Point
13d. STREET AND NUMBER: 11914 Lee Street
13e. ZIP CODE: 46307
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): 10th; College (1-4 or 5+): ------

PARENTS

18. FATHER'S NAME (First, Middle, Last): Franklin Pierce Davidson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Julia (Unknown) Hetzner

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Reba Davidson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11914 Lee Street, Crown Point, Ind. 46307
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Chapel Lawn Memorial Gard. April 30, 1991
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: William E. Burdan
22b. EMBALMER'S LICENSE NO.: FD01007697
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William E. Burdan
24b. LICENSE NUMBER (of Licensee): FD01007697
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burdan Funeral Home FH83002461 12901 Wicker Ave, Cedar lake, Ind. 46303

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. Respiratory failure.
DUE TO (OR AS A CONSEQUENCE OF)
b. Chronic obstructive lung disease
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.

Approximate Interval Between Onset and Death

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

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: Edward F. Faren
29c. MEDICAL LICENSE NO.: 01033200
29d. DATE SIGNED (Month Day Year): 5/1/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Edward F. Fara M.D. 761-45th Ave. Suite C Munster IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.
32. DATE FILED (Month Day Year): MAY 6 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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