* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2292-95 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

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.)
JAMES	ROBERT	WILCOX SR.	Male	9:24 P M	October 5, 1995

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)
404-56-4588	53					APR 19, 1942	MADISONVILLE, KY

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)
No	N/A	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
ST. MARY MEDICAL CENTER	HOBART	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	RUTH WILLIAMSON	BAR OWNER	TAVERN

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	LAKE	LAKE STATION	2850 VANDERBURG

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+)
46405	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	6	

PARENTS

18 FATHER'S NAME (First, Middle, Last)			19 MOTHER'S NAME (First, Middle, Maiden Surname)		
MAYNARD	ROBERT	WILCOX	AUDREY	G.	BROWN

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
RUTH WILCOX	2850 VANDERBURG, LAKE STATION, IN 46405	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)	OCT 10, 1995 CALUMET PARK CEMETERY	MERRILLVILLE, IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
JAMES J. KRAUSE	FD01006463	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Kenneth P. Stowers	FD08900027	FH8300513 REES FUNERAL HOME, OLSON CHAPEL 5341 CENTRAL AVE., PORTAGE, IN 46368

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. Enter only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Laceration of brain	Unknown
DUE TO (OR AS A CONSEQUENCE OF)	b. Skull fracture	
DUE TO (OR AS A CONSEQUENCE OF)	c. Due to a gunshot wound to the head	
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 previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28 WAS AUTOPSY PERFORMED? (Yes or no)	29 DID AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	Yes	Yes

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

Deputy

29b SIGNATURE AND TITLE OF CERTIFIER	29c MEDICAL LICENSE NO.	29d DATE SIGNED (Month, Day, Year)
Donna Melyon	N/A	October 10, 1995

HEALTH OFFICER

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

Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

31 HEALTH OFFICER'S SIGNATURE Alexander D. Williams, M.D. 32 DATE FILED (Month, Day, Year) Oct. 11, 1995

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	Oct 6, 1995	Unknown	No	Gunshot wound

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)
Residence	2850 Vanderburg Street Lake Station, Indiana

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
October 6, 1995	No

001594

90 1/2

CC#7275

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

Katz & Brennan 7895 B'way Mer - 46410