* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

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

Sep 11 1996 — Date Issued — Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 748

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1. Deceased-Name (First Middle Last)	Robert Lee Gray
2. Sex	Male
3a. Time of Death	1:28PM
3b. Date of Death (Month Day Yr)	September 16, 1996
4. Social Security Number	355-42-3226
5a. Age - Last Birthday (Years)	50
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo Day Yr)	Aug 11, 1946
7. Birthplace (City and State or Foreign Country)	Mt. Carmel, IL
8a. Was Decedent a U.S. Veteran?	Yes
8b. Year Last Served in U.S. Armed Forces	1970
9a. Place of Death	Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	4937 Elm
9c. City Town or Location of Death	Hammond
9d. County of Death	Lake
10. Marital Status	Married
11. Surviving Spouse (If wife, give maiden name)	Eleanor Ruth Hayes
12a. Decedent's Usual Occupation	Crane Inspector
12b. Kind of Business Industry	U.S. Steel/Manufactor
13a. Residence - State	IN
13b. County	Lake
13c. City Town or Location	Hammond
13d. Street and Number	4937 Elm
13e. Zip Code	46323
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
16. Race	White
17. Decedent's Education (Elementary/Secondary (0-12), College (1-4 or 5+))	

PARENTS

Field	Value
18. Father's Name (First, Middle, Last)	Robert Lee Gray
19. Mother's Name (First, Middle, Maiden Surname)	Bettilu Bender

INFORMANT

Field	Value
20a. Informant's Name	Eleanor Ruth Gray
20b. Mailing Address	4937 Elm Avenue, Hammond, IN 46327
20c. Relationship	Wife

DISPOSITION

Field	Value
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition	Sep 19, 1996 Elmwood Cemetery
21c. Location - City or Town State	Hammond, IN
22a. Embalmer's Name	James W. Gholston
22b. Embalmer's License No.	1004194
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	[signature]
24b. License Number	1045362
25. Name Address and License Number of Funeral Home	3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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)		Approximate Interval Between Onset and Death
a.	MYOCARDIAL INFARCTION	1 Hour
b.	DUE TO (OR AS A CONSEQUENCE OF)	
c.	DUE TO (OR AS A CONSEQUENCE OF)	
d.	DUE TO (OR AS A CONSEQUENCE OF)	

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.

Field	Value
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.

Field	Value
29b. Signature and Title of Certifier	[signature]
29c. Medical License No	01035201
29d. Date Signed (Month Day Year)	Sept 9/18/96
30. Name and Address of Person Who Completed Cause of Death (Item 26)	C.J. Sanders M.D., 7905 Calumet Avenue, Hammond Clinic, Munster, IN 46321

HEALTH OFFICER

Field	Value
31. Health Officer's Signature	Franklin J. Bremuda M.D.
32. Date Filed (Month Day Year)	SEP 18 1996

FILED

Field	Value
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)	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.	No

OCT 3 1996

SAM ORLICH AUDITOR LAKE COUNTY 000228

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

96 065876

96 OCT -3 AM 10:13

RECORDER

Key # 36-127-39

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

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