* 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.

Blackmun Bomberger, 9006 Indpls Blvd. Highland 46322

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2804-95 State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First Middle Last)	ROBERT L. ANDERSON
2. Sex	MALE
3a. Time of Death	5:01 PM (11:01 PM struck)
3b. Date of Death (Month Day Yr)	DECEMBER 10, 1995
4. Social Security Number	317-12-4123
5a. Age—Last Birthday (Years)	77
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo Day Yr)	Oct. 14, 1918
7. Birthplace (City and State or Foreign Country)	Lebanon, Indiana
8a. Was Decedent a U.S. Veteran?	Yes WWII
8b. Year Last Served in US Armed Forces?	1946
9a. Place of Death	Hospital: XX Inpatient ☐ ER/Outpatient ☐ DOA; Other: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. Facility Name	COMMUNITY HOSPITAL
9c. City, Town or Location of Death	MUNSTER
9d. County of Death	LAKE
10. Marital Status	Married
11. Surviving Spouse (If wife, give maiden name)	Grace L. Main
12a. Decedent's Usual Occupation	Professor
12b. Kind of Business/Industry	Purdue University
13a. Residence—State	Indiana
13b. County	Lake
13c. City, Town or Location	Hammond
13d. Street and Number	842-173rd Street
13e. Zip Code	46324
13f. Inside City Limits	☐ No ☒ Yes
13g. On a Farm?	XX No ☐ Yes
14. Citizen of What Country?	U.S.A.
15. Was Decedent of Hispanic Origin?	XX No ☐ Yes
16. Race	White
17. Decedent's Education: Elementary/Secondary (0-12)	12
17. College (1-4 or 5+)	4

PARENTS

Field	Entry
18. Father's Name (First Middle Last)	Stanley Martin Anderson
19. Mother's Name (First Middle Maiden Surname)	Elizabeth May James

INFORMANT

Field	Entry
20a. Informant's Name	Mrs. Grace Louise Anderson
20b. Mailing Address	842-173rd St. Hammond, IN 46323
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. Method of Disposition	XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. Date and Place of Disposition	December 14, 1995 Chapel Lawn Memorial Gardens
21c. Location—City or Town, State	Schererville, Indiana
22a. Embalmer's Name	David McCoy
22b. Embalmer's License No.	FDO8700581
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	David J. McCoy
24b. License Number (of Licensee)	FDO8700581
25. Name, Address and License Number of Funeral Home	Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. 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): Metastatic Carcinoma of the Colon

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not previously listed 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)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT DEC 12 1995 [signature] LAKE COUNTY HEALTH COMMISSIONER

FILED DEC 17 1996 SAM ORLICH AUDITOR LAKE COUNTY

CERTIFIER

29a. Certifier (Check only one): XX 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: Salman Gailani

29c. Medical License No.: IN 27970

29d. Date Signed (Month Day Year): DECEMBER 11, 1995

30. Name and Address of Person Who Completed Cause of Death (Item 26): SALMAN GAILANI, M.D. 9116 COLUMBIA AVENUE MUNSTER, IN. 46321

HEALTH OFFICER

31. Health Officer's Signature: [signature] M.D.

32. Date Filed (Month Day Year): December

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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				

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.

001098

#15439

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

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