* 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.

Local No. C907-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

9700995

DECEDENT

1 DECEASED—NAME (First Middle Last): Robert Paul Yarrington
2 SEX: Male
3a TIME OF DEATH: 10:35 A
3b DATE OF DEATH (Month Day Yr): May 1, 1996
4 SOCIAL SECURITY NUMBER: 352-12-2341
5a AGE—Last Birthday (Years): 72
5b UNDER 1 YEAR (Months, Days)
5c UNDER 1 DAY (Hours, Minutes)
6 DATE OF BIRTH (Mo. Day Yr): May 19, 1923
7 BIRTHPLACE (City and State or Foreign Country): Illinois
8a WAS DECEDENT A US VETERAN? Yes
8b YEAR LAST SERVED IN US ARMED FORCES? Marine
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Mary's Medical Center
9c CITY, TOWN OR LOCATION OF DEATH: Hobart
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Ernie Lee Robinson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Expiditer
12b KIND OF BUSINESS/INDUSTRY: SteelMill
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Lake Station
13d STREET AND NUMBER: 2710 Clay Street
13e ZIP CODE: 46405
13f INSIDE CITY LIMITS: ☐ No [X] Yes
13g ON A FARM? ☐ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? USA
15 WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 12; College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First Middle Last): Sherman Yarrington
19 MOTHER'S NAME (First Middle Maiden Surname): Edith Brady

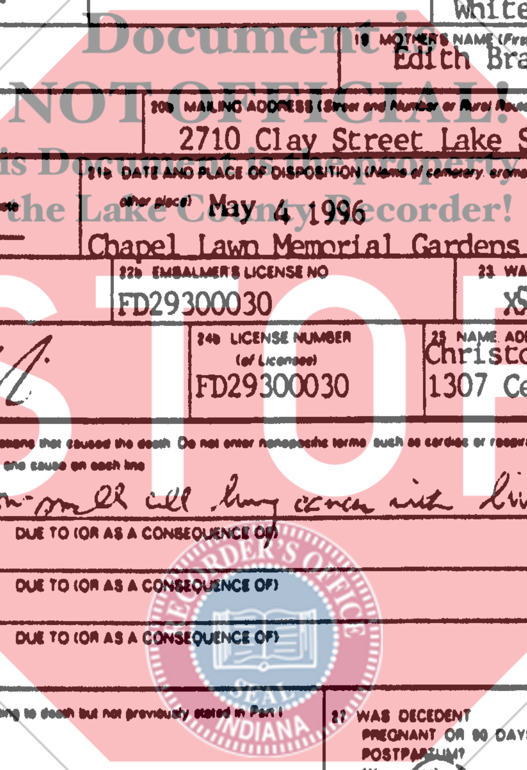
INFORMANT

20a INFORMANT'S NAME (Type/Print): Ernie Yarrington
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2710 Clay Street Lake Station IN 46405
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 4 1996, Chapel Lawn Memorial Gardens
21c LOCATION—City or Town, State: Schererville, Indiana
22a EMBALMER'S NAME: Christopher Podgorski
22b EMBALMER'S LICENSE NO: FD29300030
23 WAS DEATH REPORTED TO CORONER? [X] No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): FD29300030
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Christopher Funeral Home Fh19500025, 1307 Central Ave. Lake Station IN 46405

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 FEB 18 PM 2:14
MORRIS W. CARTER
RECORDER



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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. Non-small cell lung cancer with liver metastasis
DUE TO (OR AS A CONSEQUENCE OF)
b.
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: Emphysema

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):
[X] 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: P Tara MD
29c MEDICAL LICENSE NO: 01031667
29d DATE SIGNED (Month Day Year): May 2, 1996
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): P.J. Tara, MD 8127 Merrillville Rd Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD
32 DATE FILED (Month Day Year): May 1996

FILED

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.

FEB 18 1997

SAM ORLICH
AUDITOR LAKE COUNTY

900

000508

7803 W. 75th Ave St. 1 Sch. 46375
R Wendell Good

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