* 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.

6CC

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. ...0556-97..... State No. .....

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

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.)
Minnie	Mae	Robinson	Female	9:30 PM	February 28, 1997

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)
323-26-1118	78			December 3, 1918	Winona, Mississippi

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 XXX 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
Northlake Nursing & Rehabilitation	Merrillville	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	A. G. Robinson	Homemaker	Home

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	4264 West 21st Place

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)	
46404	XXX No ☐ Yes	XXX No ☐ Yes	U S A	XXX ☐ Yes	Black	Elementary/Secondary (0-12): 6th	College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Dave Brack	Ophelia (UNKNOWN)

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
A. G. Robinson	4264 West 21st Place Gary, Indiana 46407	Husband

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
XXX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	March 5, 1997 Oak Hill Cemetery	Gary, Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Roosevelt Allen Sr.	#01051696	XXX ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
	#08700298	Guy & Allen Funeral Directors, Inc 83007704 2959 West 11th Avenue Gary, Indiana 46404

CAUSE OF DEATH

26 PART I. Enter the chain of events—diseases, 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)	Cardiopulmonary arrest	
Due to (or as a consequence of)	Chronic obstructive lung disease	
Due to (or as a consequence of)		
Due to (or as a consequence of)		

MAR 17 1997

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

Alexander S. Williams, MD

LAKE COUNTY HEALTH COMMISSIONER

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

Diabetes Mellitus

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	

CERTIFIER

29a CERTIFIER (Check only one)

XXX 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	0103280	3/14/97

HEALTH OFFICER

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

Dr. S. Shah 5825 Broadway Merrillville, Indiana 46410

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD

32 DATE FILED (Month, Day, Year): March 17, 1997

FILED

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				APR 03 1997

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)

SAM ORLICH AUDITOR LAKE COUNTY

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

000182

Unit #25 Key #47-449-21 Block 2 Subdivision 2nd Tarrytown

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

STATE OF INDIANA LAKE COUNTY I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE COPY OF THE ORIGINAL RECORD APR -3 AM 9:29 JOHN M. CARTER RECORDER