

* 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

Key # 26-231-1

CERTIFICATE OF DEATH

State No.

Local No. 2004-97

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Robert Wilson		2 SEX Male	3a TIME OF DEATH 9:00A M	3b DATE OF DEATH (Month Day Year) October 1, 1997	
4 *SOCIAL SECURITY NUMBER 308-12-7418	5a AGE—Last Birthday (Years) 76	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Year) Feb. 18, 1921	
7 BIRTHPLACE (City and State or Foreign Country) Vincennes, IN	8a WAS DECEDENT A US VETERAN? Yes				
8b YEAR LAST SERVED IN US ARMED FORCES? 1945	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				
9a FACILITY NAME (If not institution, give street and number) 1318 Oakwood	9b CITY, TOWN OR LOCATION OF DEATH Griffith	9c COUNTY OF DEATH Lake			
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Beatrice Bennett	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) foreman	12b KIND OF BUSINESS/INDUSTRY Picture Framing		
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Griffith	13d STREET AND NUMBER 1318 N. Oakwood		
13e ZIP CODE 46319	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (13-16 or 17+)		18 FATHER'S NAME (First Middle Last) Raymond Wilson			
19 MOTHER'S NAME (First Middle Maiden Surname) Lucille Thompson		20a INFORMANT'S NAME (Type/Print) Beatrice Wilson			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 N. Oakwood Griffith, IN 46319		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) October 6, 1997 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Schererville, IN	
22a EMBALMER'S NAME Brian T. Burns		22b EMBALMER'S LICENSE NO. 8601763	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of Licensee) 1045184	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #8800135 921 W. 45th Griffith, IN 46319		
26 PART I CAUSE OF DEATH (List the disease, injury or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory failure, shock or heart failure. List only one cause on each line.) IMMEDIATE CAUSE (Final disease or condition resulting in death) OCT 02 1997 METASTATIC CANCER UNKNOWN DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS (if any) which gave rise to the immediate cause, stating the relationship of each cause to the immediate cause LAKE COUNTY HEALTH COMMISSIONER					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I EMPHYSEMA ATHEROSCLEROTIC HEART DISEASE					
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) ---	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated <input type="checkbox"/> 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 <input type="checkbox"/> 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 <i>Kevin</i>			29c MEDICAL LICENSE NO. 0703	29d DATE SIGNED (Month, Day, Year) 10/1/97	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Kevin 7905 Calumet Munster, Indiana 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander J. Williams MD</i>					
32 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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. 000567			

STATE OF INDIANA
LAKE COUNTY
FILED
RECORDS
OCT 12 1997
PH 12:22
OFFICE OF THE CLERK
COURT HOUSE
GRIFFITH, INDIANA

FILED

AUDITOR SAM ORLICH
OCT 1, 1997
LAKE COUNTY

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