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

CERTIFICATE OF DEATH

Local No. 1860-98 State No. .....

26427

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Robert J Branchaw

2 SEX: Male

3a TIME OF DEATH: 9:33 PM

3b DATE OF DEATH (Month, Day, Yr.): August 18, 1998

4 SOCIAL SECURITY NUMBER: 316-30-1782

5a AGE—Last Birthday (Years): 66

5b UNDER 1 YEAR (Months, Days):

5c UNDER 1 DAY (Hours, Minutes):

6 DATE OF BIRTH (Mo. Day Yr): Oct. 4, 1931

7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana

8a WAS DECEDENT A U.S. VETERAN? YES

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1955

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number): The Community Hospital

9c CITY, TOWN OR LOCATION OF DEATH: Munster

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Joanne Kauzlarich

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Metallurgical Tester

12b KIND OF BUSINESS/INDUSTRY: Steel Co.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Highland

13d STREET AND NUMBER: 3347 42nd St.

13e ZIP CODE: 46322

13f INSIDE CITY LIMITS? ☐ No ☒ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 10; College (1-4 or 5+): 2

PARENTS

18 FATHER'S NAME (First, Middle, Last): Al Branchaw

19 MOTHER'S NAME (First, Middle, Maiden Surname): Genevieve Kozlowski

INFORMANT

20a INFORMANT'S NAME (Type/Print): Joanne Branchaw

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3347 42nd St. Highland, Indiana

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): August 21, 1998 Chapel Lawn Cemetery

21c LOCATION—City or Town, State: Schererville, Indiana

22a EMBALMER'S NAME: Ronald A. Reed

22b EMBALMER'S LICENSE NO: FDO 100181

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: James S Lacanca

24b LICENSE NUMBER (of Licensee): FDO 1010850

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF): b.

DUE TO (OR AS A CONSEQUENCE OF): c.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated 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)

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.

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c MEDICAL LICENSE NO: 01031764

29d DATE SIGNED (Month, Day, Year): 8-19-98

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR PRAKASH MAKAM M.D. 9122 Columbia AVE Munster IN 46321

31 HEALTH OFFICER'S SIGNATURE: Alejandro Rivera, MD

32 DATE FILED (Month, Day, Year): August 21, 1998

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)

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.

00170750

CS

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