

6cc
93-0248

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER
USE ONLY

1. DECEASED—NAME (First Middle Last) HENRY FLOYD ROBINSON		2. SEX Male	3a. TIME OF DEATH 12:30 a.	3b. DATE OF DEATH (Month, Day, Yr.) March 30, 1993	
4. SOCIAL SECURITY NUMBER 408-12-1760	5a. AGE—Last Birthday (Years) 82	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) Feb. 2, 1911	7. BIRTHPLACE (City and State or Foreign Country) Vicksburg, Mississippi
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution give street and number) Methodist Hospital Northlake Campus		9c. CITY, TOWN, OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Margaret Cooper	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Custodian		12b. KIND OF BUSINESS/INDUSTRY Gary School City	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 1552 Garfield Street	
13e. ZIP CODE 46404	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) Afro Amer	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5 +)
18. FATHER'S NAME (First Middle Last) John Butler Robinson		19. MOTHER'S NAME (First Middle Maiden Surname) Lucy Jones			
20a. INFORMANT'S NAME (Type/Print) Margaret Robinson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1552 Garfield St., Gary, Indiana 46404		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) April 2, 1993 Ridgelawn Cemetery		21c. LOCATION—City or Town State Gary, Indiana	
22a. EMBALMER'S NAME Sherman G. Banks III		22b. EMBALMER'S LICENSE NO. FDO 1016254		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Paula L. Warner</i>		24b. LICENSE NUMBER (of Licensee) FDO 9100591		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell Warner & Son 4209 Grant St., Gary, IN 46408 99900011	
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. Advanced Metastatic Adenocarcinoma of the Prostate				More than one year	
b. DUE TO (OR AS A CONSEQUENCE OF)				FILED	
c. DUE TO (OR AS A CONSEQUENCE OF)				OCT 01 1999	
d. DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
27. WAS DECEDENT A PATIENT IN A HOSPITAL OR NURSING HOME AT THE TIME OF DEATH? NO		28. WAS AN AUTOPSY PERFORMED? NO		29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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>x. George D. Smalls</i>			29c. MEDICAL LICENSE NO. 01026488	29d. DATE SIGNED (Month, Day, Year) April 1, 1993	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) GEORGE D. SMALLS, M.D. 535 West 36th Avenue, Gary, Indiana 46408					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) APR. 2 1993	
33. 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.			