* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 1192-98

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

2000 031481

FILED

MORRIS W. CARTER RECORDER

DECEDENT

1. DECEASED-NAME (First Middle Last): DALE LEWIS ROBINSON
2. SEX: Male
3a. TIME OF DEATH: 4:30PM
3b. DATE OF DEATH (Month Day Yr): May 20, 1998
4. SOCIAL SECURITY NUMBER: 306-10-4194
5a. AGE - Last Birthday: 82
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): January 22, 1916
7. BIRTHPLACE (City and State or Foreign Country): Wheeler, Indiana
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): HOSPITAL: [x] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Mary 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): Virginia C. Frye
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Switchman
12b. KIND OF BUSINESS INDUSTRY: Railroad
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 1027 W. 41st Avenue
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [x] Yes
13g. ON A FARM?: [x] 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): 10; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Millard Robinson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Baker

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Virginia C. Robinson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1027 W. 41st Avenue, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [x] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 23, 1998 McCool Cemetery
21c. LOCATION - City or Town State: Portage, Indiana
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER?: [x] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. Ventricular fib
DUE TO (OR AS A CONSEQUENCE OF): b. Bleeding ulcer
DUE TO (OR AS A CONSEQUENCE OF): c.
Conditions if any which gave rise to the immediate cause stating the underlying cause last: 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 PREGNANT OR 12 MONTHS POSTPARTUM? (Yes or no): No
28a. AUTOPSY? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

I CERTIFY THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

APR 18 2000

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
MAY 05 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

COMMUNITY TITLE COMPANY
FILE NO 2180880P

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: M. Gasparis
29c. MEDICAL LICENSE NO: 01037515
29d. DATE SIGNED (Month Day Year): 22 May 98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Milton Gasparis MD, 1400 S. Lake Park Avenue, Suite 301, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month Day Year): 22 May 1998

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.

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SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1