5cc

Local No. 92-0587

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Robert C. Olsen		2 SEX: Male	3a TIME OF DEATH: 1:38 A M	3b DATE OF DEATH (Month Day Yr.): August 24, 1992	
4 SOCIAL SECURITY NUMBER: 266-50-9596	5a AGE—Last Birthday (Years): 53	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day. Yr.): Aug. 29, 1938	7 BIRTHPLACE (City and State or Foreign Country): Pensacola, Florida
8a WAS DECEDENT A US VETERAN?: NO	8b YEAR LAST SERVED IN US ARMED FORCES?: N/A	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): 4137 Tyler		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): Cheryl Ross	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Yard master	12b KIND OF BUSINESS/INDUSTRY: Steel Co.		
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN, OR LOCATION: Gary	13d STREET AND NUMBER: 4137 Tyler		
13e ZIP CODE: 46408	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): 12	College (1-4 or 5+):				

PARENTS

18 FATHER'S NAME (First, Middle, Last): Adrian Olsen	19 MOTHER'S NAME (First, Middle, Maiden Surname): Ruby Roche

INFORMANT

20a INFORMANT'S NAME (Type/Print): Cheryl Olsen	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4137 Tyler Gary, Idniana	20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 28, 1992 Pensacola Memorial Gardens	21c LOCATION—City or Town, State: Pensacola, Florida
22a EMBALMER'S NAME: David peterson	22b EMBALMER'S LICENSE NO: FDO 8601585	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b LICENSE NUMBER (of Licensee): FDO 1014511	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Fuenral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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 Carcinoma of colon with extensive
DUE TO (OR AS A CONSEQUENCE OF): Metastasis to Liver & Bone — 2 yrs

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

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Malignant Cachexia severe pain.

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): N/A	28a WAS AN AUTOPSY PERFORMED? (Yes or no): NO	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
[signature] M.D.	010356958	8-24-92

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 25 East 84th Ave. Merrillville, In. 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] MD/MPH/RC

32 DATE FILED (Month, Day, Year): AUG. 25 1992

CORONER USE ONLY

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 IF INJURY OCCURRED IN A PUBLIC PLACE, SPECIFY LOCATION (Street and Number or Rural Route Number, City or Town, State)

34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify):

34f DESCRIBE HOW INJURY OCCURRED:

34g DATE PRONOUNCED DEAD (Month, Day, Year):

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

9.00 CS AC

1/37

2000 085318

STATE OF INDIANA
FILED
2000 NOV 21 PM 2:
RECORDER

Document Mail Back to Information Sheet

This is where you want the recorded document sent back t when it has completed the recording process.

Name Jessica Cornelius

Address 867 W 66 Place

City StZip Merr. IN 46410

Telephone (219) 736 1082

Signature Printed Jessica Cornelius

Signature Written Jessica Cornelius

Date of Signature 11-21-00

Check Number #

Check Amount Cash 24.00

Office Use Only

Check Equals Amount Due ☐ Yes ☐ No

Total 24.00

Initials AC