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Key# 46-271-24
44184-28

* **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

Local No. 01 0731

CERTIFICATE OF DEATH

State No. 2002 113705

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED--NAME (First, Middle, Last): Robert Benard Jr.
2. SEX: Male
3a. TIME OF DEATH: 11:00 A M
3b. DATE OF DEATH (Month, Day, Yr.): November 16, 2001
4. SOCIAL SECURITY NUMBER: 426-32-3885
5a. AGE--Last Birthday (Years): 76
5b. UNDER 1 YEAR Months / Days
5c. UNDER 1 DAY Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): March 17, 1925
7. BIRTHPLACE (City and State or Foreign Country): Natchez, Mississippi
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?
9. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: Inpatient / ER/Outpatient / DOA; OTHER: Nursing Home / X Residence / Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 346 Cleveland Street
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): Florence Benard
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Welder
12b. KIND OF BUSINESS/INDUSTRY: Budd Plant
13a. RESIDENCE--STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 346 Cleveland Street
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: No / X Yes
13g. ON A FARM?: X No / Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): Black
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): Robert Benard Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice (Unavailable)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Florence Benard
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 346 Cleveland Street Gary, Indiana 46404
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): November 24, 2001 Evergreen Memorial Park
21c. LOCATION--City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Sherman G. Banks III
22b. EMBALMER'S LICENSE NO.: FD 01016254
23. WAS DEATH REPORTED TO CORONER?: No / X Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Glenna Sandum-Smith
24b. LICENSE NUMBER (of Licensee): FD20000361
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Smith Bizzell & Warner Funeral Home, FH19600034, 4209 Grant St, Gary, IN, 46408

CAUSE OF DEATH

29. 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.	Respiratory insufficiency	Days
DUE TO (OR AS A CONSEQUENCE OF): b.	Carcinoma of lung.	Years
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: 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.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No)
28a. WAS AN AUTOPSY PERFORMED? (Yes or No)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

FILED
DEC 10 2002

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: Michael Kovacich MD
29c. LICENSE NO.: PETER BENJAMIN LAKE COUNTY AUDITOR
29d. DATE SIGNED (Month, Day, Year): 11-26-01

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Michael Kovacich MD 8777 Broadway Merrillville IN. 46410
31. HEALTH OFFICER'S SIGNATURE: Michael Kovacich MD
32. DATE FILED (Month, Day, Year): NOV 26 2001

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.

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SDH06-004 State Form 10110-06 (R4/3-93) Deathcer/PD 1