* 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.

Local No. 1496-00

392687

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 15-491-21

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): ROBIN GREEK
2. SEX: FEMALE
3a. TIME OF DEATH: 11:16 AM
3b. DATE OF DEATH (Month, Day, Yr.): JUNE 23, 2000
4. *SOCIAL SECURITY NUMBER: 313-62-3330
5a. AGE—Last Birthday (Years): 45
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Dec.31, 1954
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: –
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): Never Married
11. SURVIVING SPOUSE (If wife, give maiden name): –
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Manager
12b. KIND OF BUSINESS/INDUSTRY: Tire
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 1526 W. 74th Place
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
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): Johnnie Greek
19. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Shallberg

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Barbara Greek
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1526 W. 74th. Pl. Merrillville,IN 46410
20c. Relationship: Mother

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): June 26, 2000 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville,Indiana
22a. EMBALMER'S NAME: Leonard Gregorczyk
22b. EMBALMER'S LICENSE NO.: FD08800305
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Leonard Gregorczyk
24b. LICENSE NUMBER (of Licensee): FD08800305
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: STILINOVICH & WIATROLIK FH830044 7535 Taft St.Merrillville,IN4641

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. INTRACEREBRAL HEMORRHAGE — Approximate Interval Between Onset and Death: 5 DAYS

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

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

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

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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): 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) 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) 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.: 01047960
29d. DATE SIGNED (Month, Day, Year): 6-27-00
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DAVID ROTHBART, M.D., 9003 CALUMET AVENUE, SUITE 501, MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): June 28, 2000

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.

000960

9.00 LP Cash

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JUN 28 2000
Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
DEC 12 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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STOP
RECORDER'S OFFICE SEAL

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