Local No. 1077

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# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Dec 27, 1991 — Franklin D. Fernandez M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED—NAME (First, Middle, Last): Robert F. Rowe
2. SEX: Male
3a. TIME OF DEATH: 1:48 PM
3b. DATE OF DEATH (Month, Day, Yr.): December 26, 1991
4. SOCIAL SECURITY NUMBER: 314-10-8848
5a. AGE—Last Birthday (Years): 71
5b. UNDER 1 YEAR — Months / Days:
5c. UNDER 1 DAY — Hours / Minutes:
6. DATE OF BIRTH (Mo, Day, Yr.): January 14, 1920
7. BIRTHPLACE (City and State or Foreign Country): Hammond, 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): St. Margaret's Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Joan Stack
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Mail Carrier
12b. KIND OF BUSINESS/INDUSTRY: US Government
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7146 Harrison
13e. ZIP CODE: 46324
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): Arthur Rowe
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen O'Connor

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Joan Rowe
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7146 Harrison HAMMOND, INDIANA 46324
20c. Relationship: Wife

**DISPOSITION**

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 28, 1991 — St. Joseph Cemetery-
21c. LOCATION—City or Town, State: Hammond, IN
22a. EMBALMER'S NAME: Charles Wells
22b. EMBALMER'S LICENSE NO.: FD01042372
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: William C. Huber
24b. LICENSE NUMBER (of Licensee): FD01001463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Dalton & Son F.H. FH83002829 — 6955 Southeastern- Hammond, IN 46324



**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. Pulmonary Edema
DUE TO (OR AS A CONSEQUENCE OF):
b. End-Stage Parkinsons
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.

Approximate Interval Between Onset and Death



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) 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: James R Miller MD
29c. MEDICAL LICENSE NO.: 01035142
29d. DATE SIGNED (Month, Day, Year): Dec 12/27/91

**HEALTH OFFICER**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): James R Miller, MD 521 E 86th Ave Merr IN 46410
31. HEALTH OFFICER'S SIGNATURE: Franklin D. Fernandez M.D.
32. DATE FILED (Month, Day, Year): December 27, 1991

**CORONER USE ONLY**

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

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