* 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

CERTIFICATE OF DEATH

Local No. 211 — State No. 20050036 BT

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ROBERT NYLAND
2. SEX: M
3a. TIME OF DEATH: 3:15 PM
3b. DATE OF DEATH (Month, Day, Yr): July 7, 2004
4. *SOCIAL SECURITY NUMBER: 317-14-8219
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): AUG 24, 1925
7. BIRTHPLACE (City and State or Foreign Country): CHICAGO IL
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946
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. CATHERINE'S
9c. CITY, TOWN, OR LOCATION OF DEATH: EAST CHICAGO
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): SINGLE
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): OFFICE WORKER
12b. KIND OF BUSINESS/INDUSTRY: UNION CARBIDE
13a. RESIDENCE—STATE: IN
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: WHITING PO (HAMMOND)
13d. STREET AND NUMBER: 1933 SUPERIOR AVE
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☐ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): W
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 NYLAND
19. MOTHER'S NAME (First, Middle, Maiden Surname): GLADYS MOORE

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LAURA ZOLKES
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 643 BURTON Ct. WHITING IN
20c. Relationship: EXE.

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Entombment ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 10, 2004 CHAPEL LAWN
21c. LOCATION—City or Town, State: SCHERERVILLE IN
22a. EMBALMER'S NAME: Thomas Owens
22b. EMBALMER'S LICENSE NO: 1001049
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature] Thos Owens
24b. LICENSE NUMBER (of Licensee): 1001049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: OWENS 119th ... WHITING IN 3927291

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. Hypotension
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)
28a. WAS AN AUTOPSY PERFORMED? (Yes or no)
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

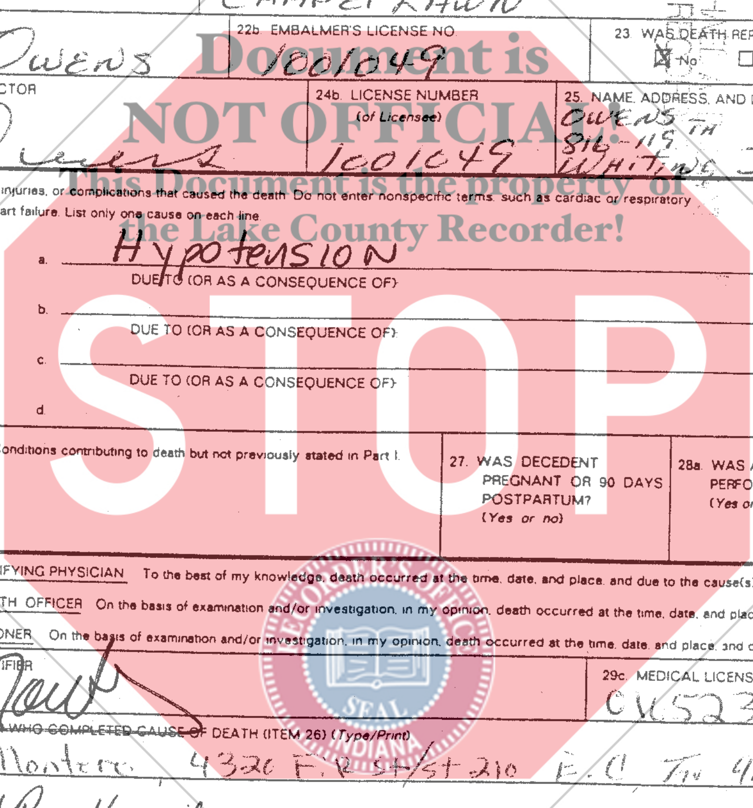
29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to 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: X [signature]
29c. MEDICAL LICENSE NO: 01052348
29d. DATE SIGNED (Month, Day, Year): 7/15/04
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Jaime Ruiz-Montero 4320 E. 151st St 210 E.C. IN 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Dr Timothy Raykovich
32. DATE FILED (Month, Day, Year): July 15, 2004
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.

BURNET TITLE
36-306-31 (26)
2005 008679

FILED MAR - 1 2005 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR
000006



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SDH06-004 State Form 10110 (R5/1-99)