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. 06 0426 — State No. .....

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

1. DECEDENT—NAME (First, Middle, Last): ROBERT J. ARANDA			2. SEX: Male	3a. TIME OF DEATH: 5:25p M	3b. DATE OF DEATH (Month, Day, Yr.): August 5, 2006
4. *SOCIAL SECURITY NUMBER: 316-30-1343	5a. AGE—Last Birthday (Years): 67	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr): May 23, 1939	7. BIRTHPLACE (City and State or Foreign Country): East Chicago,
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1964	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): 2345 Colfax St.		9c. CITY, TOWN, OR LOCATION OF DEATH: Gary		9d. COUNTY OF DEATH: Lake	
10. MARITAL STATUS (Specify): Single	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): Steelworker		12b. KIND OF BUSINESS/INDUSTRY: L.T.V.	
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Gary		13d. STREET AND NUMBER: 2345 Colfax St.	
13e. ZIP CODE: 46406	13f. INSIDE CITY LIMITS? ☐ No ☒ Yes	14. CITIZEN OF WHAT COUNTRY: USA	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.): Mexican	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+):
	13g. ON A FARM? ☒ No ☐ Yes				
18. FATHER'S NAME (First, Middle, Last): Ignacio Aranda		19. MOTHER'S NAME (First, Middle, Maiden Surname): Hortencia Gutierrez			
20a. INFORMANT'S NAME (Type/Print): Leonard Aranda		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2345 Colfax St. Gary, Ind. 46408			20c. Relationship: Brother
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): Ridgelawn Cemetery August 10, 2006			21c. LOCATION—City or Town, State: Gary, Indiana
22a. EMBALMER'S NAME: Anthony S. Rendina Jr.		22b. EMBALMER'S LICENSE NO.: FD01010402		23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR: Anthony S. Rendina Jr.		24b. LICENSE NUMBER (of Licensee): FD01010402		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rendina Funeral Home FH83007819 5100 Cleveland St. Gary, In 46408	

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. Metastatic Hepatocellular carcinoma

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. DUE TO (OR AS A CONSEQUENCE OF):

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

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)
	01042343	8.9.06

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): H. Irakhra M. D. 9108 Columbia Ave. Ste B. Munster, Indiana 46321

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year): AUG 14 2006

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY Ooccurred
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

FILED 015842 — AUG 18 2006 — PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR — $11 CS

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