152995

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. 239

City Of East Chicago
East Chicago, In 46312

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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 L. Carter, Sr.
2. SEX: Male
3a. TIME OF DEATH: 4:43P. M
3b. DATE OF DEATH (Month, Day, Yr.): October 4, 2006
4. *SOCIAL SECURITY NUMBER: 303-46-6600
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): August 22, 1943
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): Regency Hospital of Northwest Indiana
9c. CITY, TOWN, OR LOCATION OF DEATH: East Chicago
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Jeanette Jones
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Brick Mason (retired)
12b. KIND OF BUSINESS/INDUSTRY: Inland Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 4695 Washington Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 12th; College (1-4 or 5 +):

PARENTS

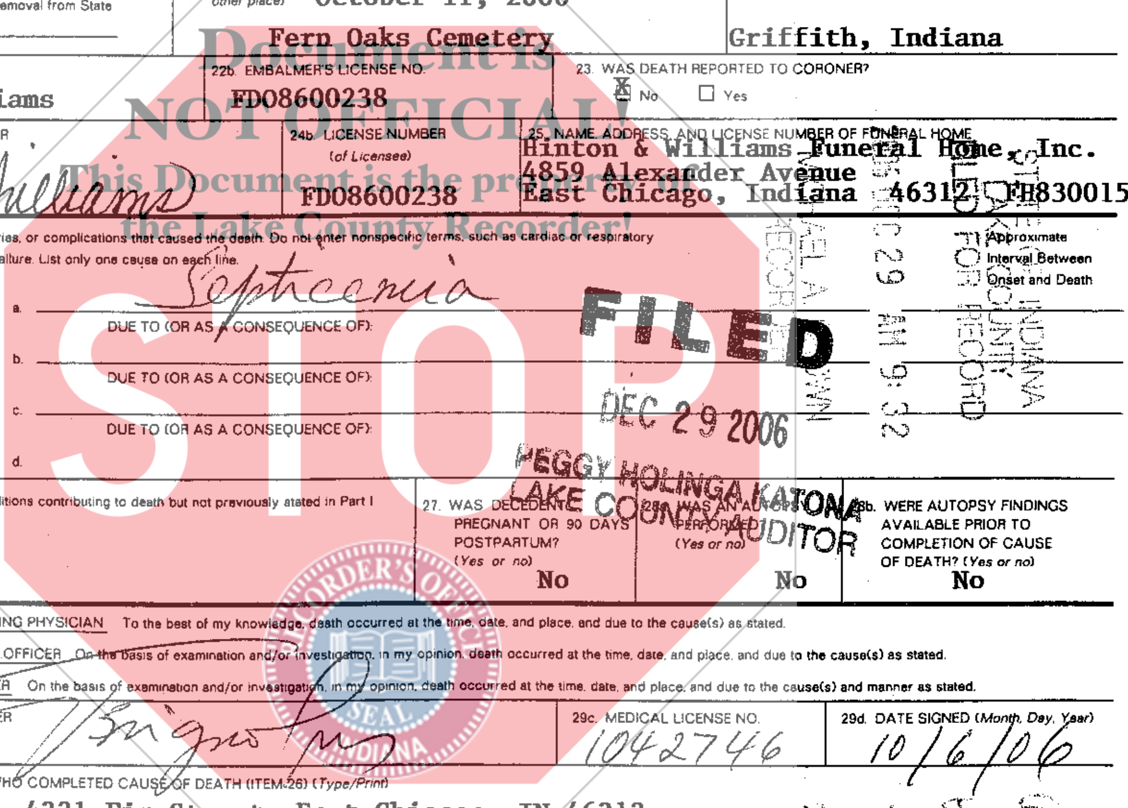
18. FATHER'S NAME (First, Middle, Last): William Carter
19. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Ellison

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Jeanette Carter
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4695 Washington St. Gary, Indiana 46408
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 11, 2006 Fern Oaks Cemetery
21c. LOCATION—City or Town, State: Griffith, Indiana
22a. EMBALMER'S NAME: Tracy Cheri Williams
22b. EMBALMER'S LICENSE NO.: FD08600238
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Tracy Cheri Williams
24b. LICENSE NUMBER (of Licensee): FD08600238
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Hinton & Williams Funeral Home, Inc. 4859 Alexander Avenue East Chicago, Indiana 46312 FH83001520



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. Septicemia
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

Approximate Interval Between Onset and Death

FILED
DEC 29 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
2006 DEC 29 AM 9:32
MICHAEL A. BROWN RECORDER

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)
[X] 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: Brignol MD
29c. MEDICAL LICENSE NO.: 1042746
29d. DATE SIGNED (Month, Day, Year): 10/6/06
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Y. Brignol 4321 Fir Street East Chicago, IN 46312

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month, Day, Year): 10/10/06

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.

027076

Parcel #45-07-15-301-016

IVRA-20 (7/95)

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

VOID IF ALTERED OR ERASED - NOT VALID UNLESS CERTIFIED BY HEALTH DEPARTMENT