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

* 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.

Key #32-78-7

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 820

State — Dec 7, 2004 Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	ROBERT L. MASSEY, SR.
2. Sex	MALE
3a. Time of Death	7:55 PM
3b. Date of Death (Month, Day, Yr)	NOVEMBER 30, 2004
4. *Social Security Number	232-18-4547
5a. Age—Last Birthday (Years)	84
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	OCTOBER 18,1920
7. Birthplace (City and State or Foreign Country)	LEEVALE, WEST VIRGINIA
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)	7415 WHITE OAK AVENUE
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)	KATHRYN TUCKER
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	FOREMAN
12b. Kind of Business/Industry	LTV STEEL COMPANY
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town, or Location	HAMMOND
13d. Street and Number	7415 WHITE OAK AVENUE
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) / College (1-4 or 5+)	6th

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	HARRISON MASSEY
19. Mother's Name (First, Middle, Maiden Surname)	PEARL PETTRY

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	KATHRYN J. MASSEY
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7415 WHITE OAK AVE.,HAMMOND,INDIANA 46324
20c. Relationship	WIFE

DISPOSITION

Field	Entry
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)	DECEMBER 4, 2004 SOLAN-PRUZIN CREMATORY
21c. Location—City or Town, State	SCHERERVILLE,INDIANA
22a. Embalmer's Name	DEAN G. WAGNER
22b. Embalmer's License No.	8800057
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	Dean G. Wagner (signature)
24b. License Number (of Licensee)	8800057
25. Name, Address, and License Number of Funeral Home	SOLAN-PRUZIN FUNERAL HOME FH83002893 7109 CALUMET AVE.,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 / due to	Approximate Interval Between Onset and Death
a. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Congestive Cardiac Failure	years
b. DUE TO (OR AS A CONSEQUENCE OF):	Chronic Obstructive Pulmonary Dis	years
c. DUE TO (OR AS A CONSEQUENCE OF):	Black Lung	years
d. DUE TO (OR AS A CONSEQUENCE OF):	Diabetes, Renal Failure	years

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

Field	Entry
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.

Field	Entry
29b. Signature and Title of Certifier	(signature)
29c. Medical License No.	01052493
29d. Date Signed (Month, Day, Year)	DECEMBER 3, 2004
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)	SAKHAWAT HUSSAIN, M.D. 3315 W. 93rd STREET, CHICAGO, ILLINOIS

HEALTH OFFICER

Field	Entry
31. Health Officer's Signature	(signature) MD
32. Date Filed (Month, Day, Year)	December 6, 2004

Field	Entry
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.	

FILED JAN 17 2006 PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

092072

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

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