45-08-24-331-013-000-020

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 1391-09 State No.

1. Decedent's Legal Name (First, Middle, Last): ROBERT EARLE JOHNSON
1a. Maiden Last Name (If Female): N/A
2. Sex: M
3. Time Of Death: 8:22 AM
4. Date Of Death (Month/Day/Year): APRIL 1, 2009
5. Social Security Number: 524-07-1573
6a. Age Yrs: 87
6b. Under 1 Year: Months
6c. Under 1 Month: Days
6d. Under 1 Day: Hours
6e. Under 1 Hour: Minutes
7. Date Of Birth (Month/Day/Year): March 26, 1922
8. Birthplace (City And State Or Foreign Country): PUEBLO, COLORADO
9. Ever In U.S. Armed Forces? ☒ Yes ☐ No Unknown ☐
10. If Death Occurred In A Hospital: ☒ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival
10a. If Death Occurred Somewhere Other Than A Hospital: ☐ Hospice Facility ☐ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)
11. Facility Name (If Not Institution, Give Street And Number): ST. MARY MEDICAL CENTER
12. City Or Town, State, And Zip Code: HOBART, INDIANA 46342
13. County Of Death: LAKE
14. Marital Status At Time Of Death: ☒ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☐ Never Married ☐ Unknown
15. Surviving Spouse's Name: N/A
15a. (If Wife) Give Maiden Last Name: N/A
16. Decedent's Usual Occupation: SALESMAN
17. Kind Of Business/Industry: REAL ESTATE
18. Residence – State: INDIANA
18a. County: LAKE
18b. City Or Town: LAKE STATION
18c. Street And Number: 2736 E. 37TH AVE.
18d. Apt. No.: N/A
18e. Zip Code: 46405
18f. Inside City Limits? ■ Yes ☐ No
19. Decedent's Education: Some college credit, but no degree
20. Decedent Of Hispanic Origin: No, not Spanish/Hispanic/Latino
21. Decedent's Race: White
22. Father's Name (First, Middle, Last): EMMETT M. JOHNSON
23. Mother's Name (First, Middle, Last): THELMA BERNICE JOHNSON
23a. Mother's Maiden Last Name: MCKAY
24. Informant's Name: JOSHUA JOHNSON
24a. Relationship To Decedent: SON
24b. Mailing Address (Street And Number, City, State, Zip Code): 3468 REVERE CT. LAKE STATION, INDIANA 46405

25. Place Of Disposition
25a. Method Of Disposition: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):
25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place): MEMORY LANES
25c. Location – City, Town, And State: SCHERERVILLE, INDIANA
26. Was Coroner Contacted? ☐ Yes ☒ No
27. Name And Complete Address Of Funeral Facility: KUIPER FUNERAL HOME 9039 KLEINMAN RD. HIGHLAND,INDIANA 46322
27a. Funeral Home License Number: FH10002...
27b. Signature Of Indiana Funeral Service Licensee: [signature]
27c. License Number (Of Licensee): FD08800305

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

Approximate Interval Onset To Death

Immediate Cause (Final Disease Or Condition Resulting In Death) A. Respiratory failure
Due To (Or As A Consequence Of):
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last B. Renal failure
Due To (Or As A Consequence Of):
C. Possible prostate cancer
Due To (Or As A Consequence Of):
D.

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I
29. Was An Autopsy Performed? ☐ Yes ☒ No
30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☒ No
31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☐ No ☒ Unknown
32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year
33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined
34. Date Of Injury (Month/Day/Year):
35. Time Of Injury
36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)
37. Injury At Work? ☐ Yes ☐ No
38. Location Of Injury - State
38a. City Or Town
38b. Street & Number
38c. Apt. No.
38d. Zip Code
39. Describe How Injury Occurred
40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)
41. Signature Of Person Certifying Cause Of Death: [signature]
42. Certifier (Check Only One): ☒ Certifying Physician ☐ Coroner ☐ Health Officer
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: Dr. Abbud 8300 Broadway Ste A-1 Mville, IN 46410
44. License Number: 01058415A
45. Date Certified: 4-2-2009
46. Additional Funeral Service Provider:
47. "Akas:
48. Signature of Local Health Officer: Susan W Burt, D.O.
49. For Registrar Only – Date Filed (Month/Day/Year): April 2, 2009

2009 026642

FILED
APR 08 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

008895

STATE OF INDIANA, LAKE COUNTY, FILED FOR RECORD
2009 APR -8
MICHAEL A. BROWN, RECORDER

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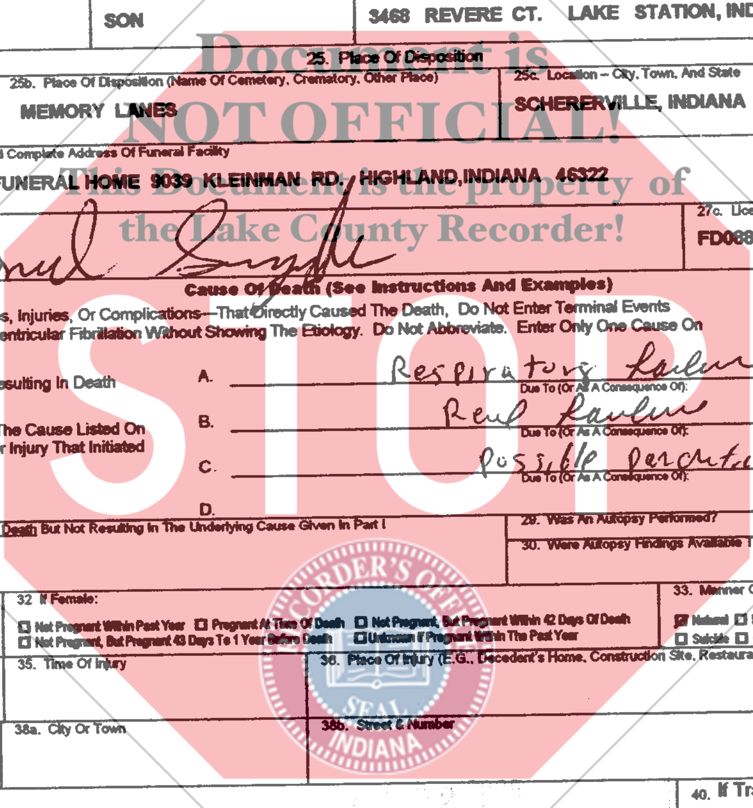
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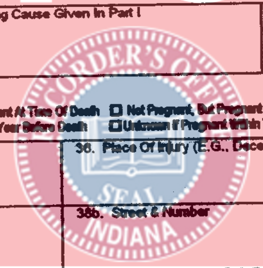

State Form 10110 (R7/9-07)