

Key # 45-08-07-455-031,000-004

ATTENTION ESTATE: Disclosure of the S# we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 94-0343

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Robert Lee Mayo		2 SEX Male	3a TIME OF DEATH 10:20A M	3b DATE OF DEATH (Month Day Yr.) May 13, 1994	
4 *SOCIAL SECURITY NUMBER 496-20-6186	5a AGE—Last Birthday (Years) 2009	5b UNDER 1 YEAR 062248	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr.) 2009 SEP 17 1923	
7 BIRTHPLACE (City and State or Foreign Country) Neelyville, Missouri	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) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) RESIDENCE		
9b FACILITY NAME (If not institution, give street and number) 3746 West 20th Place	9c CITY TOWN OR LOCATION OF DEATH Gary	9d COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Leola Vaughn	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 Inland Steel Co.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 3746 West 20th Place		
13e ZIP CODE 46404	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) Afro Am	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 08 College (1-4 or 5 +)		18 FATHER'S NAME (First, Middle, Last) Arthur Mayo			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Tucker		20a INFORMANT'S NAME (Type/Print) Leola Mayo			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3746 W. 20th Pl., Gary, Indiana 46404		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 19, 1994 Evergreen Cemetery		21c LOCATION—City or Town, State Hobart, Indiana	
22a EMBALMER'S NAME Sherman G. Banks III		22b EMBALMER'S LICENSE NO. FD01016254	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Paula L. Warner</i>		24b LICENSE NUMBER (of Licensee) FD09100591	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell Warner, Inc. FH89900011 4209 Grant St., Gary, Indiana 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. <u>GASTRIC CANCER</u> DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____				Approximate Interval Between Onset and Death 3 mo	
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		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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 <i>Walter Stadler</i>		29c MEDICAL LICENSE NO. IL 036-081259	29d DATE SIGNED (Month, Day, Year) 5/18/94		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Walter Stadler 5841 S. Maryland Avenue Chicago, Illinois 60637					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) MAY 18 1994	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF DEATH (Month, Day, Year) SEP 10 2009	34b TIME OF DEATH INJURY	34c INJURY AT WORK? (Yes or no) 34d DESCRIBE HOW INJURY OCCURRED PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR	
34g DATE PRONOUNCED PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR					

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



FILED

FILED

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR

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