INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000993 **EDR No** 000000220556 **State No** 041647

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
MARGIE A PRITCHETT	ROBINSON	FEMALE	05:11 AM	09/22/2011

5. Social Security Number	6a. Age - Yrs	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)	8. Birthplace (City and State or Foreign Country)
316-26-4422	84					10/08/1926	PULTNEY, OH

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): VNA HOSPICE CENTER

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
VALPARAISO, IN, 46383	PORTER	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife) Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
		SALES CLERK	RETAIL

18. Residence - State	18a. County	18b. City Or Town
INDIANA	LAKE	HOBART

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
117 HARRISON AVENUE		46342	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
HIGH SCHOOL GRADUATE OR GED COMPLETED	NOT HISPANIC	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
HARRY ROBINSON	CLARA ROBINSON	FOWLER

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
MICHAEL PRITCHETT	SON	2107 FLEMMING ROAD, VALPARAISO, IN 46385

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	LOWELL CEMETERY	LOWELL, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☐ Yes ☒ No	REES FUNERAL HOME, HOBART CHAPEL, 600 W OLD RIDGE RD, HOBART, IN 46342	FH83003069

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
JAMES J. KRAUSE , BY ELECTRONIC SIGNATURE	FD01006463

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. LUNG CA	6-12 MONTHS
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. COPD	YEARS
	C.	
	D.	

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I: NO

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?	32. If Female:	33. Manner Of Death:
☐ Yes ☐ Probably ☐ No ☒ Unknown	☐ 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	☒ 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 (At Work, 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:	42. Certifier (Check Only One)
MARK OREN CARTER , BY ELECTRONIC SIGNATURE	☒ Certifying Physician ☐ Coroner ☐ Heath Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
MARK OREN CARTER , 164 BRACKEN PKWY, HOBART, IN 46342	01036415A	09/23/2011

46. Additional Funeral Service Provider:	47. *Akas:

48. Signature of Local Health Officer:	49. For Registrar Only - Date Filed (Month/Day/Year):
MARIA L STAMP, VIA ELECTRONIC SIGNATURE	SEP 23 2011

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

Parcel # 45-09-19-358-013.000-022

11.00 CS RM

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.