Qc

* 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. 04-1194

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 042613

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): Norma L. Robbins
2. SEX: Femal
3a. TIME OF DEATH: 8:45 PM
3b. DATE OF DEATH (Month, Day, Yr.): December 11, 2004
4. *SOCIAL SECURITY NUMBER:
5a. AGE-Last Birthday (Years): 85
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): October 13, 1919
7. BIRTHPLACE (City and State or Foreign Country): Munci , 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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 8400 W CR 400S
9c. CITY, TOWN, OR LOCATION OF DEATH: Yorktown
9d. COUNTY OF DEATH: Delaware
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Walter C. Robbins
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Clerk
12b. KIND OF BUSINESS/INDUSTRY: Department Store
13a. RESIDENCE–STATE: Indiana
13b. COUNTY: Delaware
13c. CITY, TOWN, OR LOCATION: Yorktown
13d. STREET AND NUMBER: 8400 W CR 400S
13e. ZIP CODE: 47396
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE- American Indian, Black, White etc (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): August Haas
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Worthen

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Walter C. Robbins
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8400 W CR 400S, Yorktown, IN 47396
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 15, 2004 Gardens of Memory Cemetery
21c. LOCATION – City or Town, State: Muncie, Indiana
22a. EMBALMER'S NAME: James R. Fornoff
22b. EMBALMER'S LICENSE NO.: FD01005386
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Gordon Cox
24b. LICENSE NO (of Licensee): FD01006201
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: The Meeks Mortuary, Inc 415 E. Washington St., Muncie, IN 47305 FH83004918

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. End Stage Renal Disease
DUE TO (OR AS A CONSEQUENCE OF)
b. Arteriosclerotic Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Diabetes mellitus, Hypothyroidism.
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.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. MEDICAL LICENSE NO.: 01027720
29d. DATE SIGNED (Month, Day, Year): 12/13/04

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): St ven Allen, M.D., 1910 W. Royale Dr., Muncie, IN 47304
31 HEALTH OFFICER'S SIGNATURE: Donna R. Wilkins MD
32 DATE FILED (Month, Day, Year): DEC 1 3 2004

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined
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.

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