* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

007989

Local No. 8103 State No.

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): Myron Foulke Robbins
2. SEX: Male
3a. TIME OF DEATH: 3:50AM
3b. DATE OF DEATH (Month Day Yr): March 6, 2006
5a. AGE - Last Birthday (Years): 94
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo Day Yr): August 26, 1911
7. BIRTHPLACE (City and State or Foreign Country): Noblesville, 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): Americare Living Center
9c. CITY TOWN OR LOCATION OF DEATH: Westfield
9d. COUNTY OF DEATH: Hamilton
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Machinist
12b. KIND OF BUSINESS INDUSTRY: Biddle Precision Components
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Hamilton
13c. CITY TOWN OR LOCATION: Westfield
13d. STREET AND NUMBER: 776 North Union Street
13e. ZIP CODE: 46074
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Oscar Clifton Robbins
19. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Foulke

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Joan Heine
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1562 West 525 North, Lebanon, Indiana 46052
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): March 9, 2006 Crown View Cemetery
21c. LOCATION - City or Town State: Sheridan, Indiana
22a. EMBALMER'S NAME: Leesa M. Kercheval
22b. EMBALMER'S LICENSE NO.: FDO8601527
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Morris J. Kercheval
24b. LICENSE NUMBER (of Licensee): FDO1011571
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: 83007877 Kercheval Funeral Home P.O. Box 42; Sheridan, Indiana 46069

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. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF)
b. 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.

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): N/A

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) as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. MEDICAL LICENSE NO: 01027775
29d. DATE SIGNED (Month Day Year): March 6, 2006

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Robert D. Habig, M.D., 15229 U.S. 31 North, Box 840, Westfield, Indiana 46024

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Charles Harris, MD
32. DATE FILED (Month Day Year): MAR 07 2006

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.

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

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