

\* 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.

# INDIANA STATE DEPARTMENT OF HEALTH

044975

Local No. 225-05 BP# 738168

## CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

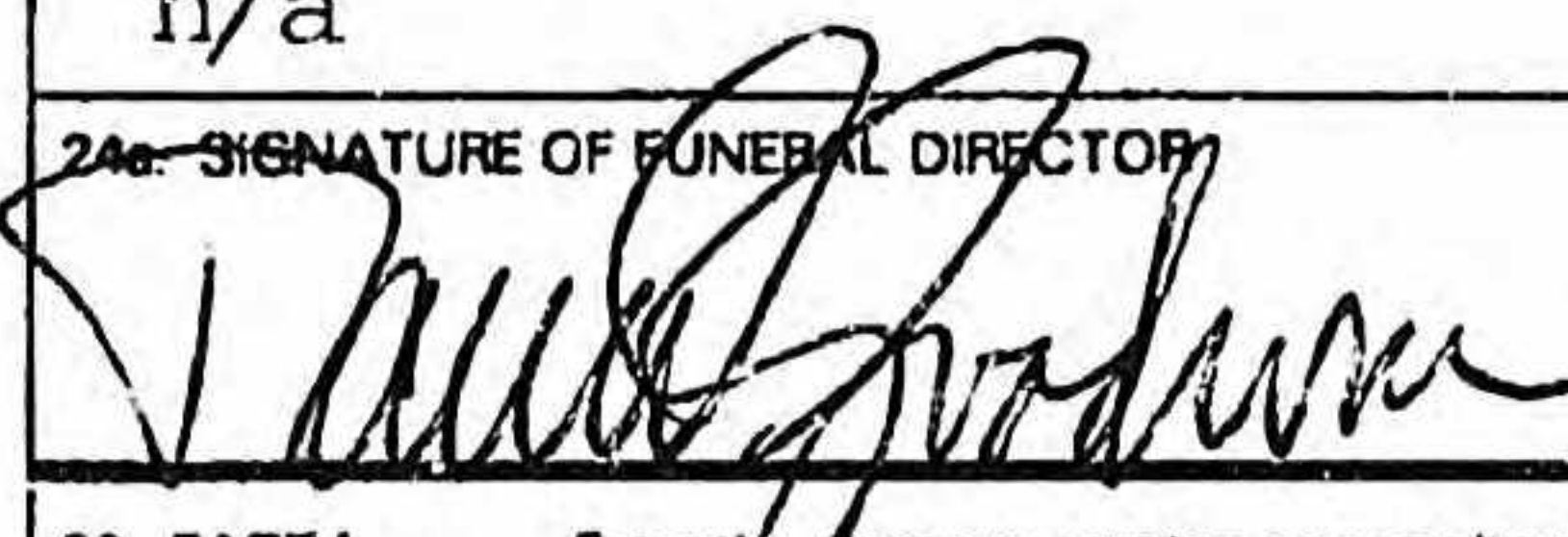
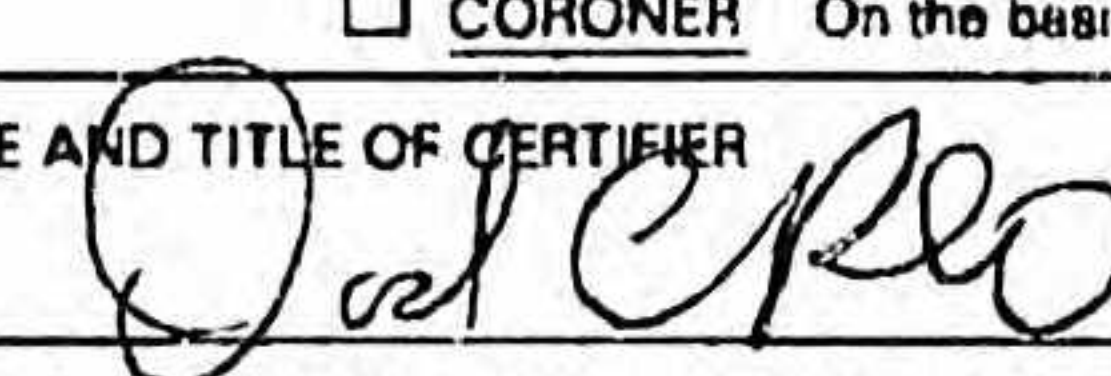
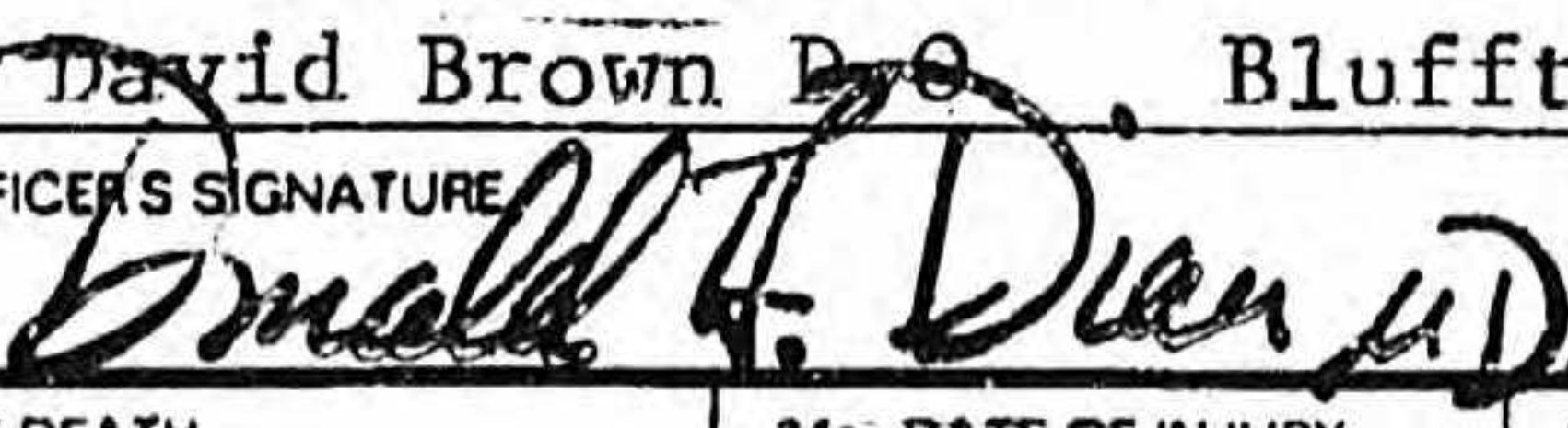
INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1 DECEASED—NAME (First, Middle, Last) Milton Robbins			2 SEX male		3a. TIME OF DEATH 8:20 A M	3b. DATE OF DEATH (Month, Day, Yr) Dec 18, 2005
5a. AGE—Last Birthday (Years) 79		5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) April 28, 1926		7. BIRTHPLACE (City and State or Foreign Country) Henry Co, IN
8a. WAS DECEDENT A U.S. VETERAN? n/a	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) Bluffton Regional Med Center			9c. CITY, TOWN, OR LOCATION OF DEATH Bluffton		9d. COUNTY OF DEATH Wells	
10. MARITAL STATUS (Specify) married		11. SURVIVING SPOUSE (If wife, give maiden name) Ellen Kilgore		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) farmer		12b. KIND OF BUSINESS/INDUSTRY farming
13a. RESIDENCE—STATE IN		13b. COUNTY Wells	13c. CITY, TOWN, OR LOCATION Montpelier		13d. STREET AND NUMBER 2641 E 1100 S-90	
13a. ZIP CODE 47359	13f. INSIDE CITY LIMITS <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) white	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) Oscar C Robbins			19. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Fulke			
20a. INFORMANT'S NAME (Type/Print) Ellen Robbins			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2641 E 1100 S-90, Montpelier, IN 47359			20c. Relationship wife
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) Dec 21, 2005 Wilson Burial Vault & Crematory			21c. LOCATION—City or Town, State Huntington, IN	
22a. EMBALMER'S NAME: n/a		22b. EMBALMER'S LICENSE NO		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) FD01017195		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Goodwin Memorial Chapel, FH83000443 3220 E St Rd 124, Bluffton, IN 46714		
26. PART I. Enter the disease, 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>End stage Encephalopathy</u> DUE TO (OR AS A CONSEQUENCE OF) b. <u>Uro sepsis</u> DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____  Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last						
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 			29c. MEDICAL LICENSE NO 02 000 345A		29d. DATE SIGNED (Month, Day, Year) 12-19-05	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) David Brown D.O., Bluffton, Indiana						
31. HEALTH OFFICER'S SIGNATURE 					32. DATE FILED (Month, Day, Year) DEC 20 2005	
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 INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED	
34a. 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.				