* **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. 2003-367

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 015236

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 F. ROBBINS JR.
- 2. SEX: MALE
- 3a. TIME OF DEATH: 11:44 A.M.
- 3b. DATE OF DEATH (Month, Day, Yr.): MAY 26, 2003
- 4. *SOCIAL SECURITY NUMBER:
- 5a. AGE—Last Birthday (Years): 66
- 5b. UNDER 1 YEAR: Months / Days
- 5c. UNDER 1 DAY: Hours / Minutes
- 6. DATE OF BIRTH (Mo, Day, Yr): JUNE 28, 1936
- 7. BIRTHPLACE (City and State or Foreign Country): SHERIDAN, IN
- 8a. WAS DECEDENT A U.S. VETERAN?: YES
- 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: UNKNOWN
- 9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
- 9b. FACILITY NAME (If not institution, give street and number): HOWARD COMMUNITY HOSPITAL
- 9c. CITY, TOWN, OR LOCATION OF DEATH: KOKOMO
- 9d. COUNTY OF DEATH: HOWARD
- 10. MARITAL STATUS (Specify): MARRIED
- 11. SURVIVING SPOUSE (If wife, give maiden name): GAIL NOLAND
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MARKETING ENGINEER
- 12b. KIND OF BUSINESS/INDUSTRY: TELEPHONE
- 13a. RESIDENCE—STATE: IN
- 13b. COUNTY: HOWARD
- 13c. CITY, TOWN, OR LOCATION: KOKOMO
- 13d. STREET AND NUMBER: 5505 RUHL GARDEN DRIVE
- 13e. ZIP CODE: 46902
- 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): ; College (1-4 or 5+): 4

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): MYRON F. ROBBINS SR.
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): IRENE BROWN

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): GAIL ROBBINS
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5505 RUHL GARDEN DR. KOKOMO, IN 46902
- 20c. Relationship: WIFE

DISPOSITION

- 21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 30, 2003 ALBRIGHT CEMETERY
- 21c. LOCATION—City or Town, State: KOKOMO, IN
- 22a. EMBALMER'S NAME: MATTHEW S. KAMM
- 22b. EMBALMER'S LICENSE NO: FD01019985
- 23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Daniel R. Tharp (signature) DANIEL R. THARP
- 24b. LICENSE NUMBER (of Licensee): FD29500071
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ELLERS MORTUARY, INC. FH83003849, 725 S. MAIN ST. KOKOMO, IN 46901

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. Acute Coronary Syndrome
  DUE TO (OR AS A CONSEQUENCE OF)
- b.
  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: Asthma

- 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):

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: Don P. Zent MD (signature) DON ZENT, M.D.
- 29c. MEDICAL LICENSE NO: 01024026
- 29d. DATE SIGNED (Month, Day, Year): 5/28/2003
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 2330 S. Dixon Rd Kokomo, In 46902

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: (signature) MD
- 32. DATE FILED (Month, Day, Year): MAY 30 2003

- 33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
- 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 (R5/1-99)