* **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. 2003-216

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 025034

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

TYPE/PRINT IN PERMANENT BLACK INK

16 cc

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
HELEN I. SANDERS	FEMALE	7:58 PM	JULY 13, 2003

5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr)	7 BIRTHPLACE (City and State or Foreign Country)
65			October 11, 1937	Sheridan, IN

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO		HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
WITHAM MEMORIAL HOSPITAL	LEBANON	BOONE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
WIDOW		HOMEMAKER	DOMESTIC

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
FLORIDA	PASCO	NEW PORT RICHEY	5023 BITNER ST.

13e ZIP CODE	13f INSIDE CITY LIMITS?	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
346652	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	WHITE	Elementary/Secondary (0-12): 12	College (1-4 or 5 +):

PARENTS

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

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Mark Sanders	1433 Thomas Dr., Lebanon, IN 46052	Son

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ____	July 25, 2003 Bushnell Veteran Cemetery	Bushnell, Florida

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Jerry Trapp	FD01004869	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01004869	Russell & Hitch Funeral Home 223 North Meridian St. Lebanon, IN 46052 FH83004154

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 PULMANARY EMBOLISM	IMMEDIATE
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b SADDLE EMBOLISM	
	c	
	d	

DUE TO (OR AS A CONSEQUENCE OF)

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	YES	YES

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
[signature] DEPUTY CORONER	FD01004869	JULY 17, 2003

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

JERRY TRAPP 223 N. MERIDIAN STREET, LEBANON, IN 46052

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
[signature] MD	7-17-03

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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
JULY 13, 2003	NO

SDH06-004 State Form 10110 (R5/1-99)