INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 21-88-SS 092719

State No. 77

Ernest M. Tyler 2203 W 203rd Ave Lowell 46356

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First / Middle / Last)			2. SEX	3. DATE OF DEATH (Month, Day, Year)
Charles	H.	Tyler	Male	Dec. 21, 1988

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days)	5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
312 42 6651	71			Dec. 11, 1917	Indiana

8. YEAR LAST SERVED IN U.S. ARMED FORCES?

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)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Anthonys Hosp.	Crown Point	Lake

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced, Unknown	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
Never Married		Employee	Auto Insulation

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Lowell	2203 W. 203rd Ave

13e. INSIDE CITY LIMITS? (Yes or No)	13f. FARM	13g. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE—American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed)
No	Yes	46356	☒ No ☐ Yes	White	Elementary/Secondary (0-12) / College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Henry T. Tyler	Effie Mae Roe

INFORMANT

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or R.F.D. Number, City or Town, State, Zip Code)	19c. RELATIONSHIP
Ruth Utley	805 W. Summit Crown Point, In. 46307	Sister

DISPOSITION

20a. METHOD OF DISPOSITION	20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, other place)	20c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Dec. 23, 1988 Lowell Memorial Cemetery	Lowell, In.

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER	21c. NAME AND ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD0105460	Sheets Funeral Home FD83004277 1604 E. Comm. Ave. Lowell, In.

PRONOUNCING PHYSICIAN ONLY

22a. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and Title	22b. LICENSE NUMBER	22c. DATE SIGNED (Month, Day, Year)
Delbert Smith MD	IN.30268	12/21/88

23. TIME OF DEATH	24. DATE PRONOUNCED DEAD (Month, Day, Year)	25. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No)
6:43 Am	12/21/88	No

CAUSE OF DEATH

27. PART I. Enter the sequence of events, diseases, injuries, or complications that directly caused the death. Do not enter terminal events such as cardiac arrest, respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Acute Cardiopulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF)
b. Acute Pulmonary Edema

DUE TO (OR AS A CONSEQUENCE OF)
c. Hypovolemic Shock

DUE TO (OR AS A CONSEQUENCE OF)
d. Acute Upper GI Hemorrhage

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Gastrointestinal Bleed (GSH)

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

SEE INSTRUCTIONS

CERTIFIER

29a. CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 22)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Delbert Smith MD	IN.30268	12/21/88

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)	
12110 Grant St Crown Point IN 46307	

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	DEC 22 88

CORONER OR MEDICAL EXAMINER USE ONLY

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)

SBH08-004 State Form 10110 (R/10-87) DEATH A/PD 1

#3-5-19 W2 sent to A.S. 5T32 R9W 20ac

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