Keyes 9-3...

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1516-92 93018452 State No. ......

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Donald G. Kyes
2. SEX: Male
3a. TIME OF DEATH: 11:00P
3b. DATE OF DEATH (Month Day Yr): July 13, 1992
4. SOCIAL SECURITY NUMBER: 306-34-0108
5a. AGE—Last Birthday (Years): 57
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): June 14, 1935
7. BIRTHPLACE (City and State or Foreign Country): Valparaiso, IN
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN US 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): St. Anthony Medical Center
9c. CITY, TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Hildegarde Blair
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): School Teacher
12b. KIND OF BUSINESS/INDUSTRY: C.P. School Corp.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 1131 Pettibone Avenue
13e. ZIP CODE: 46307
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+): 5+

PARENTS

18. FATHER'S NAME (First Middle Last): John Kyes
19. MOTHER'S NAME (First Middle Maiden Surname): Dorothy Swelstad

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Hildegarde Kyes
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1131 Pettibone Ave. Crown Point, IN 46307
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): July 17, 1992 Memorial Park
21c. LOCATION—City or Town, State: Valparaiso, IN
22a. EMBALMER'S NAME: Larry A. Geisen
22b. EMBALMER'S LICENSE NO.: FD09000013
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01000328
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FD83001253, 109 N. East St., Crown Point, IN 46307

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter conditions 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): Poorly Differentiated Adenocarcinoma of Colon — Approximate Interval Between Onset and Death: 1 month

DUE TO (OR AS A CONSEQUENCE OF):

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Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions: Conditions contributing to death but not resulting in the underlying cause given in Part I: Diabetes and Diabetic Amputation

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

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: [signature]
29c. MEDICAL LICENSE NO.: 01025771
29d. DATE SIGNED (Month Day, Year): 7-14-92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. David Ashbach, P. O. Box 647, Hammond, IN 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.

FILED

32. DATE FILED (Month Day, Year): July 15 1992

CORONER USE ONLY

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, Pedestrian

MAR 22 1993

Anna M. Antone
AUDITOR LAKE COUNTY

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