ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Kreis Funeral Home, 600 W. Ridge Rd, Hobart 46342

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0657-94 ..... 94022326 **CERTIFICATE OF DEATH** State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. Deceased—Name (First, Middle, Last)	BETTY MARIE FLYE
2. Sex	Female
3a. Time of Death	4:35AM
3b. Date of Death (Month, Day, Yr)	March 14, 1994
4. *Social Security Number	401-42-2301
5a. Age—Last Birthday (Years)	62
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. Date of Birth (Mo, Day, Yr)	AUG 11, 1931
7. Birthplace (City and State or Foreign Country)	KENTUCKY
8a. Was Decedent a U.S. Veteran?	No
8b. Year Last Served in U.S. Armed Forces?	N/A
9a. Place of Death (Check only one. See instructions)	Hospital: ☒ ER/Outpatient; ☐ Inpatient; ☐ DOA. Other: ☐ Nursing Home; ☐ Residence; ☐ Other (Specify)
9b. Facility Name (If not institution, give street and number)	METHODIST HOSPITAL SOUTHLAKE
9c. City, Town or Location of Death	MERRILLVILLE
9d. County of Death	LAKE
10. Marital Status (Specify)	Married
11. Surviving Spouse (If wife, give maiden name)	RAYMOND FLY
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	HOMEMAKER
12b. Kind of Business/Industry	HOME
13a. Residence—State	INDIANA
13b. County	LAKE
13c. City, Town or Location	GARY
13d. Street and Number	4148 TYLER STREET
13e. Zip Code	46408
13f. Inside City Limits?	☐ No ☒ Yes
13g. On a Farm?	☒ No ☐ Yes
14. Citizen of What Country?	USA
15. Was Decedent of Hispanic Origin? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. Race—American Indian, Black, White, etc. (Specify)	WHITE
17. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12)	8
College (1-4 or 5+)	

PARENTS

Field	Entry
18. Father's Name (First, Middle, Last)	JOSEPH HALSTEAD
19. Mother's Name (First, Middle, Maiden Surname)	VERA MAE WHITE

INFORMANT

Field	Entry
20a. Informant's Name (Type/Print)	RAYMOND FLY
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	4148 TYLER STREET, GARY, INDIANA 46408
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. Method of Disposition	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory or other place)	MAR 16, 1994 CALUMET PARK CEMETERY
21c. Location—City or Town, State	MERRILLVILLE, INDIANA
22a. Embalmer's Name	JAMES J. KRAUSE
22b. Embalmer's License No.	FDO1006463
23. Was Death Reported to Coroner?	☒ No ☐ Yes
24a. Signature of Funeral Director	James J. Krause
24b. License Number (of Licensee)	FDO1006463
25. Name, Address, and License Number of Funeral Home	FH8403069 KREIS FUNERAL HOME, INC. 600 W. OLD RIDGE RD., HOBART, IN 46342

FILED MAR 1994

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Chronic obstructive lung disease	
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

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	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	29c. Medical License No.	29d. Date Signed (Month, Day, Year)
[signature]	01032180	3/17/94

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): SURENDRA J. SHAH MD, 5825 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. Health Officer's Signature	32. Date Filed (Month, Day, Year)
Alexander S. Williams, M.D.	March 18, 1994

Field	Entry
33. Manner of Death	☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.	

#46-10-13

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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