

RESUBMIT

INDIANA STATE BOARD OF HEALTH

THIS CERTIFICATE IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 307

CERTIFICATE OF DEATH

3033 - 171st St Hammond 46323

Apr. 15, 1992

Date Issued

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) DOUGLAS GILMAN GYURE		2 SEX MALE	3a TIME OF DEATH 9:24PM	3b DATE OF DEATH (Month, Day, Year) APRIL 9, 1992	
4 SOCIAL SECURITY NUMBER 304-48-1044	5a AGE—Last Birthday (Year) 45	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month, Day, Year) July 20, 1946	
7a WAS DECEDENT A U.S. VETERAN? No	7b YEAR LAST SERVED IN U.S. ARMED FORCES? none	8a PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence			
9a FACILITY NAME (If not institution, give street and number) Residence: 6828 Alabama		9b CITY, TOWN OR LOCATION OF DEATH Hammond	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Margaret A. Dyar	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor in Maintenance	12b KIND OF BUSINESS/INDUSTRY Union Carbide Corp.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 6828 Alabama		
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) white	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 8+)		18 FATHER'S NAME (First, Middle, Last) Louis Gyure			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Delores Keister		20a INFORMANT'S NAME (Type/Print) Mrs. Margaret A. Gyure			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6828 Alabama Hammond, IN 46323		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) April 13, 1992 Shapelaw Memorial Gardens		21c LOCATION—City or Town, State Schererville, Indiana	
22a EMBALMER'S NAME David F. McCoy		22b EMBALMER'S LICENSE NO. FDO8700581	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO1013507	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH#300280 7042 Kennedy Ave. Hammond, IN 46323		
26 PART I Enter the disease, injury, 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. Occlusive coronary arteriosclerosis		26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I			
IMMEDIATE CAUSE (First disease or condition resulting in death)		DUE TO (OR AS A CONSEQUENCE OF)			
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last		DUE TO (OR AS A CONSEQUENCE OF)			
		DUE TO (OR AS A CONSEQUENCE OF)			
		DUE TO (OR AS A CONSEQUENCE OF)			
27 WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) Yes		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes	
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 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 <i>[Signature]</i> Deborah Huseman			
29c MEDICAL LICENSE NO. N/A		29d DATE SIGNED (Month, Day, Year) June 17, 1992			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Deborah Huseman, Chief Deputy Coroner, 2293 N. Main Street, Crown Point, IN 46307					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> Franklin D. Remuda, M.D.				32 DATE FILED (Month, Day, Year) June 19, 1992	
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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) April 9, 1992		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 000488			

DECEASED

PARENTS

INFORMANT

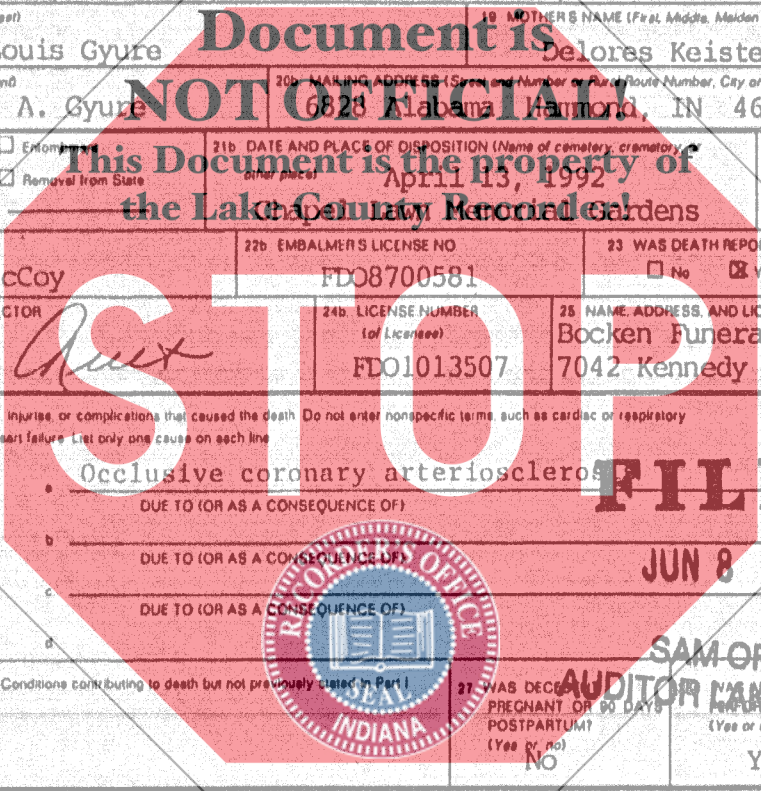
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



9502316

STATE OF INDIANA
FILED
LAKE COUNTY
RECORDED
JUN 11 1992