12cc's

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

Local No. 2057-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): CLYDE E. LAYHEW
3. SEX: Male
4a. TIME OF DEATH: 2:47AM
4b. DATE OF DEATH (Month Day Yr): September 13, 1995
5. SOCIAL SECURITY NUMBER: 185-18-0664
6a. AGE - Last Birthday (Years): 74
6b. UNDER 1 YEAR (Months Days)
6c. UNDER 1 DAY (Hours Minutes)
6. DATE OF BIRTH (Mo Day Yr): Dec 10, 1920
7. BIRTHPLACE (City and State or Foreign Country): ISABELLA, PA
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1123 DEVONSHIRE
9c. CITY TOWN OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): LOIS ZEMBOWER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MILLWRIGHT
12b. KIND OF BUSINESS/INDUSTRY: US STEEL
13a. RESIDENCE - STATE: IN
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 1123 DEVONSHIRE
14a. ZIP CODE: 46342
14b. INSIDE CITY LIMITS? ☐ No ☒ Yes
14c. 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): CHARLES H. LAYHEW, SR.
19. MOTHER'S NAME (First, Middle, Maiden Surname): LORETTA RISBECK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LOIS LAYHEW
20b. MAILING ADDRESS (Street and Number, City or Town, State, Zip Code): 1123 DEVONSHIRE, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sept 16, 1995 EVERGREEN MEMORIAL PARK
21c. LOCATION - City or Town, State: HOBART, IN
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FDO1006463
22c. WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes
23a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
23b. LICENSE NUMBER (of Licensee): FDO1006463
23c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

CAUSE OF DEATH

24. 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.
a. Chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: 5 yrs
PART II. Other significant conditions - Conditions contributing to death but not resulting in the underlying cause given in PART I.
25. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
26. WAS AN AUTOPSY PERFORMED? (Yes or no): No
27. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): No

Alexander B. Phillips, M.D.
LAKE COUNTY HEALTH COMMISSIONER

#17-109-4

CERTIFIER

28a. 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.
28b. SIGNATURE AND TITLE OF CERTIFIER: Donald M. Phillips MD
28c. MEDICAL LICENSE NO.: C102084
28d. DATE SIGNED (Month Day Year): 9/15/95

HEALTH OFFICER

29. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): DONALD M. PHILLIPS MD, 1356 SOUTH LAKE PARK AVE., HOBART, IN 46342
31. HEALTH OFFICER'S SIGNATURE: Alexander B. Phillips, M.D.
32. DATE FILED (Month Day Year): September 15, 1995

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): 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.: No

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