HOLD FOR:
THE TITLE SEARCH CO.

Key # 25 - 42 - 2 - 37

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 93-0886 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)	HOLLAND TYLER
2 SEX	MALE
3a TIME OF DEATH	9:03p M
3b DATE OF DEATH (Month Day Yr)	NOV. 17, 1993
4 SOCIAL SECURITY NUMBER	313-07-4700
5a AGE—Last Birthday (Years)	86
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	APRIL 11,1907
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?	---
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 MARY MEDICAL CENTER
9c CITY, TOWN OR LOCATION OF DEATH	GARY
9d COUNTY OF DEATH	LAKE
10 MARITAL STATUS (Specify)	MARRIED
11 SURVIVING SPOUSE (If wife, give maiden name)	MINOLA MARSHAL
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	COKE PLANT
12b KIND OF BUSINESS/INDUSTRY	US STEEL
13a RESIDENCE—STATE	IN
13b COUNTY	LAKE
13c CITY, TOWN OR LOCATION	GARY
13d STREET AND NUMBER	1333 CHASE ST
13e ZIP CODE	46404
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)	BLACK
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	Unavailable

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	JOHN A. TYLER
19 MOTHER'S NAME (First Middle Maiden Surname)	Cathren Tyler

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	GLADYS PATTERSON
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	2278 CARVER ST GARY, IN 46407
20c Relationship	DAUGHTER

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	NOV. 29 26, 1993 FERN OAKS
21c LOCATION—City or Town, State	GRIFFITH, IN
22a EMBALMER'S NAME	PAUL A. ROBINSON
22b EMBALMER'S LICENSE NO	1017284
23 WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Paul Anthony Robinson
24b LICENSE NUMBER (of Licensee)	1017284
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	ENNOIS & ROBINSON 3002495 1900 W. 15TH AVE GARY, IN

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Septecemia
DUE TO (OR AS A CONSEQUENCE OF)
c. Multiple Decub Ulcer
DUE TO (OR AS A CONSEQUENCE OF)
d.

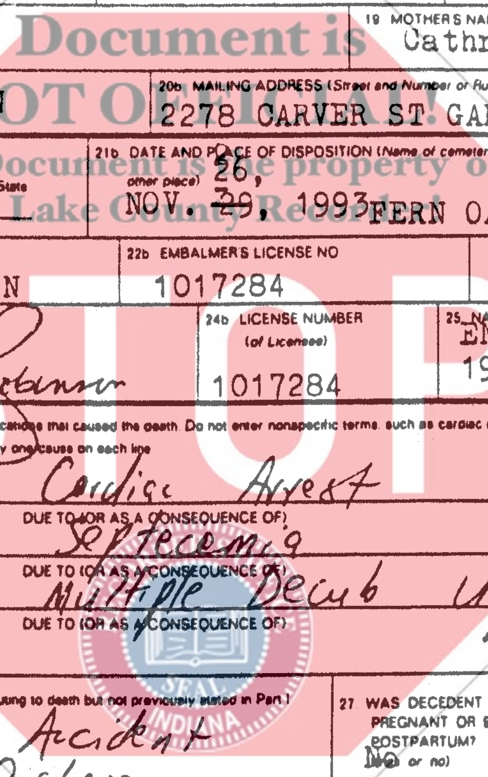
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I: Cerebrovascular Accident; Respiratory Distress

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)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STOP

FILED
APR 17 1996
SAM ORLICH
AUDITOR LAKE COUNTY

96 APR 17 PM 12:4
MARIE RECORDER
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

96024190

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: Obelia D. Duh [signature]

29c MEDICAL LICENSE NO. 01033 571

29d DATE SIGNED (Month, Day, Year) 11/18/93

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 1135 Broadway Gary Indiana 46409

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE [signature]

32 DATE FILED (Month, Day, Year) NOV. 23 1993

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 or no) If yes, specify driver, passenger, pedestrian, etc.

001115

900 / HS