

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 257

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Charles Karl Syfert		2 SEX Male	3a TIME OF DEATH 3:20 A.M.	3b DATE OF DEATH (Month Day Year) September 15, 1996	
4 SOCIAL SECURITY NUMBER 306-38-9249	5a AGE—Last Birthday (Years) 58	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Year) November 11, 1937	
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a WAS DECEDENT A U.S. VETERAN? No				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? -----		8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) St. Catherines Hospital		9b CITY, TOWN OR LOCATION OF DEATH East Chicago	9c COUNTY OF DEATH Lake Co.		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Karen Tomlinson	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Security Guard	12b KIND OF BUSINESS/INDUSTRY Hospital Security		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 3247 175th Place		
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) white	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 9th		18 FATHER'S NAME (First Middle Last) Cecil Syfert			
19 MOTHER'S NAME (First Middle Maiden Surname) Bertha Slifert		20a INFORMANT'S NAME (Type/Print) Karen Syfert			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3247 175th Place Hammond Indiana 46320		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Wednesday, Sept. 18, 1996 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME -----		22b EMBALMER'S LICENSE NO. -----	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert A. Craig</i>		24b LICENSE NUMBER (of Licensee) FD08700735	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway Merrillville, IN 46410		
26 PART I Enter the disease, 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. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF) CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)					
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I CONGESTIVE HEART FAILURE					
27 WAS DECEDENT PRESENT OR SO DAYS BEFORE DEATH? 1997 No		28a WAS AN AUTOPSY PERFORMED? No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
29a CERTIFIER (Check only one) <input checked="" 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 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>M. Gambetta</i>		29c MEDICAL LICENSE NO. 25594	29d DATE SIGNED (Month, Day, Year) 9-19-96		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Miguel A. Gambetta M.D. 4320 Fir Street East Chicago, Indiana					
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Semathey Rankovich</i>			32 DATE FILED (Month, Day, Year) 9-23-95		
33 MANNER OF DEATH <input 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)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

#36-477-15

NOT OFFICIAL

FILED

AUDITOR OF PUBLIC ACCOUNTS

MORRIS W. CARTER
RECORDER

7 APR 25 1996
PH 4: 05

INDIANA
COUNTY
RECORD

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Sep
95

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