Key# 29-55-30

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.

Local No. ......8753 ...01

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ..........................

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

2002 043677

TYPE/PRINT IN PERMANENT BLACK INK

**DECEDENT**

1. DECEASED—NAME (First, Middle, Last): NEIL D. BOYLE
2. SEX: MALE
3a. TIME OF DEATH: 1:42 A.M.
3b. DATE OF DEATH (Month, Day, Yr): NOVEMBER 8, 2001
4. *SOCIAL SECURITY NUMBER: 305-20-3660
5a. AGE-Last Birthday (Years): 72
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): SEPT. 27, 1929
7. BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
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 ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): VIRGINIA L. BEAL
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): COMPUTOR ANALYST
12b. KIND OF BUSINESS/INDUSTRY: AMOCO OIL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: WHITING
13d. STREET AND NUMBER: 1618 LaPORTE AVENUE
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): XX No ☐ Yes
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): DENIS BOYLE
19. MOTHER'S NAME (First, Middle, Maiden Surname): BRIDGET GALLAGHER

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): MRS. VIRGINIA L. BOYLE
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1618 LaPORTE AVE., WHITING, IN 46394
20c. Relationship: WIFE

**DISPOSITION**

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): NOVEMBER 12, 2001 ST. JOHN CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, INDIANA
22a. EMBALMER'S NAME: HENRY J. BLAKE
22b. EMBALMER'S LICENSE NO: FDE01019406
23. WAS DEATH REPORTED TO CORONER?: XXX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH ST., WHITING, IN 46394

**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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. LUNG CARCINOMA

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF)
c. DUE TO (OR AS A CONSEQUENCE OF)
d. DUE TO (OR AS A CONSEQUENCE OF)

Approximate Interval Between Onset and Death

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

NOV 09 2001

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Acute DVT, Renal Failure, COPD

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): N/A

**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: Pravin Gupta M.D.
29c. MEDICAL LICENSE NO: 01039588
29d. DATE SIGNED (Month, Day, Year): NOVEMBER 9, 2001
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): PRAVIN GUPTA, M.D. 929 RIDGE ROAD MUNSTER, INDIANA

FILED

MAY 9 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: [signature] D.O.
32. DATE FILED (Month, Day, Year): Nov 9, 20[01]

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.

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SDH06-004 State Form 10110 (R5/1-99)