Key # 11-9-166

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

Local No. 3693-03

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last): THOMAS MICHAEL BRYAN
2. SEX: MALE
3a. TIME OF DEATH: 8:00 PM
3b. DATE OF DEATH (Month, Day, Yr.): DECEMBER 28, 2003
4. *SOCIAL SECURITY NUMBER: 223-54-4284
5a. AGE—Last Birthday (Years): 62
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): OCTOBER 2, 1941
7. BIRTHPLACE (City and State or Foreign Country): BUTLER, PENNSYLVANIA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1966
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

DECEDENT

9b. FACILITY NAME (If not institution, give street and number): 13201 77th AVE
9c. CITY, TOWN, OR LOCATION OF DEATH: DYER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): CECELIA BOYKIN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HIGHWAY ENGINEER
12b. KIND OF BUSINESS/INDUSTRY: FEDERAL HIGHWAY DEPT.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: DYER
13d. STREET AND NUMBER: 13201 77th AVE
13e. ZIP CODE: 46311
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last): WILLIW BRYAN
19. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE BASTIN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CECELIA BRYAN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13201 77th AVE DYER, IN 46311
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 31, 2003 NORTHWEST INDIANA CREMATION SERVICES
21c. LOCATION—City or Town, State: CROWN POINT, INDIANA
22a. EMBALMER'S NAME: NOT EMBALMED
22b. EMBALMER'S LICENSE NO: N/A
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Lawrence Miller
24b. LICENSE NUMBER (of Licensee): FD01006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83001504 FAGEN-MILLER FUNERAL HOME 1920 HART ST. DYER, IN 46311

USE OF ATH

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. Esophageal Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

Approximate Interval Between Onset and Death

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE [illegible]

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

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): NO

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

CERTIFIER

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. MEDICAL LICENSE NO: [illegible]30926
29d. DATE SIGNED (Month, Day, Year): 30 Dec 03
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): [illegible] Dr Gen Surg 7905 Calumet Ave. Munster IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan J Br[illegible]
32. DATE FILED (Month, Day, Year): December 30, 2003

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.

FILED
JAN 15 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

001242

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