* **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.

Key#

OCC 2 Not 10 cc

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 16.19-04 State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
THOMAS M. SYE	Male	7:55 PM	June 29, 2004

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days)	5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
181-16-2299	82			April 12, 1922	Glenwilerd Pennsylvania

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
YES	1946	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Mary Medical Center	Hobart	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Carol McHugh	Expeditor	Steel

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	3879 Maple Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46342	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph Sye	Anna Hannigan

INFORMANT

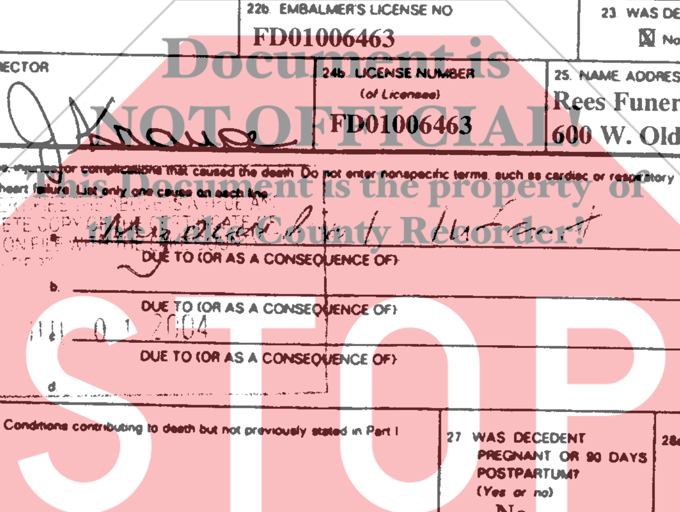
20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Carol F. Sye	3879 Maple Street, Hobart, IN 46342	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	Jul 2, 2004 Evergreen Memorial Park	Hobart IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FD01006463	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01006463	Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488



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. [handwritten] — Approximate Interval Between Onset and Death: 6/28/04

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

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No	No

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
[signature]	[handwritten]	6/30/04

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
John E. Carter MD 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	July 1, 2004

FILED 2004 STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)
	STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

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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Key# 18-176-20, 21, 22, 23

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