

RESUB

10CC INDIANA STATE DEPARTMENT OF HEALTH

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

Local No. 570-99

CERTIFICATE OF DEATH

State No.

15973 THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT INK

1. DECEASED—NAME (First, Middle, Last) Samuel E. Lyon				2. SEX Male	3a. TIME OF DEATH 4:55 A M	3b. DATE OF DEATH (Month, Day, Yr.) February 25, 1999	
4. *SOCIAL SECURITY NUMBER 426-40-4930		5a. AGE—Last Birthday (Years) 74	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) August 22, 1924		7. BIRTHPLACE (City and State or Foreign Country) Greenwood, Mississippi
8a. WAS DECEDENT A U.S. VETERAN? YES		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" 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			
9b. FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake				9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Evelyn Smith		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pump Operator		12b. KIND OF BUSINESS/INDUSTRY American Maize	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 2129 Rutledge Street	
13e. ZIP CODE 46404		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U S A		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. RACE—American Indian, Black, White, etc. (Specify) Black				17. DECEDENT'S EDUCATION (Specify only highest grade completed) 8th			
18. FATHER'S NAME (First, Middle, Last) Johnnie Lyon				19. MOTHER'S NAME (First, Middle, Maiden Surname) Monica Hansburn			
20a. INFORMANT'S NAME (Type/Print) Evelyn Lyon				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2129 Rutledge Street Gary, Indiana 46404		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) March 2, 1999 Evergreen Cemetery			21c. LOCATION—City or Town, State Michigan Indiana		
22a. EMBALMER'S NAME Roosevelt Allen Sr.		22b. EMBALMER'S LICENSE NO. #01051696		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) #08700646		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 #3007704			
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. Acute Respiratory Failure Chronic Renal Failure Hypertensive Coronary Artery Disease				27. WAS DECEASED 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) <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>[Signature]</i>			
29c. MEDICAL LICENSE NO. #01024744				29d. DATE SIGNED (Month, Day, Year) 3/25/99			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Brian Weiss MD 202 East 89th Place Merrillville, Indiana 46410							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT April 5, 1999			
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. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. 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

RENTS

FORMANT

POSITION

USE OF

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Vertical handwritten notes on the left margin: # 25-43-414-23, Parcel # 25-43-414-23



2006 AUG 31 07:36

Vertical stamp: MICHAEL EGEGY HORNKA KATONA LAKE COUNTY AUDITOR

FILED stamp: MICHAEL EGEGY HORNKA KATONA LAKE COUNTY AUDITOR

Handwritten notes and stamps: JUL 28 2006, 1100, 017091, B