

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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. 3102-96

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

41375  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) MARGARET C. SNYDER

2. SEX FEMALE

3a. TIME OF DEATH 9:28 P M

3b. DATE OF DEATH (Month, Day, Yr.) OCTOBER 30, 1996

4. \*SOCIAL SECURITY NUMBER 304-50-2746

5a. AGE—Last Birthday (Years) 83

5b. UNDER 1 YEAR Months Days

5c. UNDER 1 DAY Hours Minutes

6. DATE OF BIRTH (Mo, Day, Yr.) APRIL 12, 1913

7. BIRTHPLACE (City and State or Foreign Country) GARY, 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) 703 EAST 92nd AVENUE

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) JACK T. SNYDER

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER

12b. KIND OF BUSINESS/INDUSTRY AT HOME

13a. RESIDENCE—STATE FLORIDA

13b. COUNTY BROWARD

13c. CITY, TOWN, OR LOCATION FT. LAUDERDALE

13d. STREET AND NUMBER 123 ROYAL PALM DRIVE

13e. ZIP CODE 33301

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?  No  Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

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+)

18. FATHER'S NAME (First, Middle, Last) JAMES T. CONSIDINE

19. MOTHER'S NAME (First, Middle, Maiden Surname) SCANLON

20a. INFORMANT'S NAME (Type/Print) JACK T. SNYDER

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Royal Palm Dr., Ft. Lauderdale FL 33301

20c. Relationship HUSBAND

21a. METHOD OF DISPOSITION  Burial  Cremation  Removal from State  Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 2, 1996 N.W. Ind. Cremation Services

21c. LOCATION—City or Town, State Indiana

22a. EMBALMER'S NAME Gordon L. Jones

22b. EMBALMER'S LICENSE NO. 1010711

23. WAS DEATH REPORTED TO CORONER?  No  Yes

24a. SIGNATURE OF FUNERAL DIRECTOR Terrence P. Burns

24b. LICENSE NUMBER (of Licensee) 1013890

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDR#3002445

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. RUPTURED THORACIC AORTIC ANEURYSM

b. DUE TO (OR AS A CONSEQUENCE OF): ATHEROSCLEROSIS

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death: 3-18 MONTHS

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

- HYPERTENSION

- Colon Cancer Resection in Remission.

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

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 [Signature]

29c. MEDICAL LICENSE NO. 01034369

29d. DATE SIGNED (Month, Day, Year) 10/31/96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Zafar U. Khalid, 9001 Broadway, Merrillville, Indiana

31. HEALTH OFFICER'S SIGNATURE [Signature]

32. DATE FILED (Month, Day, Year) 11/7/96

33. MANNER OF DEATH  Natural  Pending Investigation  Accident  Suicide  Could not be Determined  Homicide

34a. DATE OF INJURY (Month, Day, Year) FEB 27 2007

34b. TIME OF INJURY

34c. INJURY AT WORK? (Yes or no)

34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) FEB 27 2007

34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)

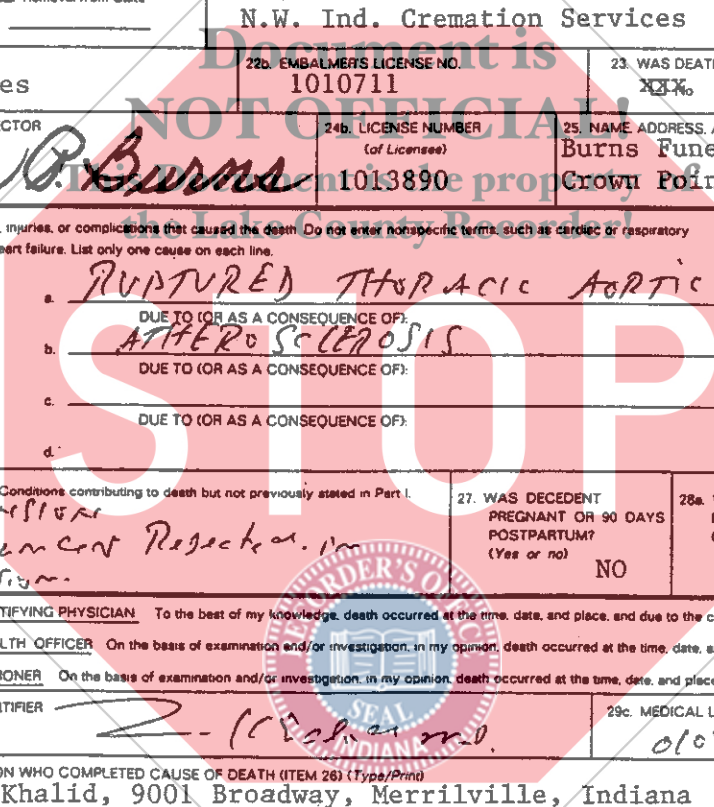
34f. DATE OF INJURY OCCURRED FEB 07 2007

34g. DATE PRONOUNCED DEAD (Month, Day, Year)

34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. EGGY HOLINGA RAYONA LAKE COUNTY AUDITOR

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LOT 8 BLK 1 GREEN MEADOW MANOR UNIT 1 IN CROWN POINT - FLAT BK 31 PAGES 1



THIS CERTIFIES THE ABOVE IS TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH MADE WITH THE LAKE COUNTY HEALTH DEPARTMENT  
FEB 07 2007  
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LH  
MTG