* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 1679-94

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED-NAME (First Middle Last)	THEODORE R. TYRE
2. SEX	Male
3a. TIME OF DEATH	12:00AM
3b. DATE OF DEATH (Month Day Yr)	August 1, 1994
4. SOCIAL SECURITY NUMBER	452-34-8730
5a. AGE - Last Birthday (Years)	67
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	Mar 15, 1927
7. BIRTHPLACE (City and State or Foreign Country)	CHICAGO, IL
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)	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	ST. MARY MEDICAL CENTER
9c. CITY TOWN OR LOCATION OF DEATH	Hobart
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	MONA L. KERNS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	CONSULTANT
12b. KIND OF BUSINESS INDUSTRY	INLAND STEEL
13a. RESIDENCE - STATE	IN
13b. COUNTY	Lake
13c. CITY TOWN OR LOCATION	Hobart
13d. STREET AND NUMBER	135 N. WABASH STREET
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN?	[X] 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): 8; College (1-4 or 5+):

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	LEROY TYRE
19. MOTHER'S NAME (First, Middle, Maiden Surname)	CLARA C. NATZEL

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	MONA L. TYRE
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	135 N. WABASH STREET, Hobart, IN 46342
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[ ] Burial [ ] Cremation [ ] Donation [X] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	Aug 3, 1994 CALUMET PARK MAUSOLEUM
21c. LOCATION - City or Town State	MERRILLVILLE, IN
22a. EMBALMER'S NAME	JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.	FDO1006463
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause
24b. LICENSE NUMBER (of Licensee)	FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. CARCINOMA OF LUNG — Approximate Interval Between Onset and Death: 1½ YRS

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

THIS CERTIFIES TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE — LAKE COUNTY HEALTH DEPARTMENT

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]	01030107	8-2-94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): BHARAT H. BARAI MD, 125 E. 89TH AVENUE, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
Alexander B. Williams MD	August 2, 1994

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, driver, passenger, pedestrian, etc.

SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

FILED

JUN 26 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

12282

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2007 JUN 26 AM 10:05

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

MICHAEL A. BROWN RECORDER