45-08-09-303-019.000-004
45-08-09-303-020.000-004

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 06 0072 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)
ROBERT LYLES		MALE	9:23a M	FEBRUARY 3, 2006
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)
427-01-9507	83		MAY 12, 1922	SHANNON, MISSISSIPPI
8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)		
YES	1946	HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence	

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
METHODIST HOSPITAL NORTHLAKE	GARY	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	MARY JENKINS	JOURNEYMAN PLASTERER	COMMERCIAL

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	GARY	1409 W.17th.AVE.

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)	
46407	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	BLK.	Elementary/Secondary (0-12): 9th.	College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
WILLIE LYLES SR.	NINA JACKSON

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
MARY LYLES	1409 W.17th.AVE.GARY, IND.46407	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
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____	FEBRUARY 10, 2006 OAK HILL CEMETERY	GARY, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
JOHN V. HOWER	8600440	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Violet E. Hower	1014618	HOWER FUNERAL HOME 3002518 1628 WASHINGTON ST. GARY, IND. 4640

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

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) X	a Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF)	
	b Atherosclerotic coronary artery disease	
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF)	
	c Diabetes Mellitus	
	DUE TO (OR AS A CONSEQUENCE OF)	
	d Hypertension, Cerebro vascular accident	

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

X Hyperlipidemia, prostate cancer

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)
N/A	NO	N/A

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)
X Staff Physician	X 01041037	X 02/07/06

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

X Ravi Puthenveettil MD ARGYLE POINTE, 9330 Broadway, Crown Point IN 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE

FILED

32 DATE FILED (Month, Day, Year) FEB 09 2006

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
☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide			DEC 06 2010	

34e PLACE OF INJURY—At home farm street factory office building etc (Specify) (Enter City and County and Number or Rural Route Number City or Town State)

EGGY HOLINGA KATONA
AKE COUNTY AUDITOR

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc