INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

Local No. 60 0052 — '59 001378 — State No.

1. PLACE OF DEATH
a. COUNTY: Lake
b. CITY, TOWN, OR LOCATION: Gary
c. Length of Stay in 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Meth. Hosp.
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES ☒ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ind. b. COUNTY: Porter
c. CITY, TOWN, OR LOCATION: Portage
d. STREET ADDRESS: 10930 E. Evergreen Ave.
e. IS RESIDENCE INSIDE CITY LIMITS? YES ☒ NO ☐
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward Middle A. Last Anderson
4. DATE OF DEATH: Month 1 Day 12 Year 60
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 20, 1877
9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U S A.
13. FATHER'S NAME: Andrew Peter Anderson
14. MOTHER'S MAIDEN NAME: Johanna Gustafson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16a. INFORMANT'S NAME: Evert Anderson
16b. INFORMANT'S ADDRESS: 834 Lincoln St. - Hobart, Ind
16c. RELATIONSHIP TO DECEASED: Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dissecting Aneurysm of aorta — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY occurred. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. ATTENDING PHYSICIAN: I certify that I attended the deceased from 1959 to death and last saw her/him alive on 1-11-59. Death occurred at 2:30 P.M. (C.S.T.) on the date stated above; and to the best of my knowledge, from the causes stated.
22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at 2:00 P.M. (C.S.T.) from causes stated and on above date.

23a. Signature of Attending Physician or Health Officer: John L. Wann M.D
23b. ADDRESS: 295 S. Wisc., Hobart, Ind
23c. DATE SIGNED: 1-13-60

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-15-60
24c. NAME OF CEMETERY ~~OR CREMATORY~~: McCook
24d. LOCATION: McCook, Ind.

DATE REC'D BY LOCAL HEALTH OFFICER: 1-14-60
SIGNATURE OF HEALTH OFFICER: R D Rosenbloom
25. FUNERAL DIRECTOR: Geo. Polinghorn
ADDRESS: Hobart, Ind

FUNERAL DIRECTOR'S LICENSE No. 1940 — EMBALMER'S LICENSE No. 3899 — EMBALMER'S NAME: Cedar Polinghorn

S.B.H.—6-24-3—Revised 1955 U. S. Department Health, Education and Welfare. Form Approved Budget Bureau No. 68-R375