

CERTIFICATE OF DEATH

Registered No. 18651

1. PLACE OF DEATH:

County LAKE
City or town GARY
Street address, hospital, or institution: METHODIST HOSP
Stay in hospital or inst. (yrs. or mos. or days)
Stay in this community (yrs. or mos. or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State INDIANA County LAKE
City or town Hobart
Street No. R#1
2. (a) IF VETERAN, NAME WAR

3. (a) FULL NAME

BARBARA FAY BECKMAN

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) JUNE 27 - 1944

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace GARY IND
(Town, county and state)

10. Usual occupation INFANT

11. Industry or business

12. Name FRED BECKMAN

13. Birthplace CHICAGO - ILL

14. Maiden name FLORENCE REICHERT

15. Birthplace HOBART - IND

16. Informant FRED BECKMAN

Address HOBART - IND

17. BURIAL Date thereof 6/29/44
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Calumet Park

Location Gary Ind. LAKE CO.

18. Funeral director German Plushaupt

Address Hobart Ind

Filed 6/29 1944 G. S. Stegeline
Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 28 1944 7P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1944 to June 28 1944 and that I last saw her alive on June 28 1944

Immediate cause of death Spastic Paralysis

Due to Cerebral hemorrhage

Other conditions 160

(Include any agency within 3 months of death)

Major findings: Post to follow
Of operations To follow
Of autopsy To follow

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Injured at work? _____ Means of injury _____

23. SIGNATURE L. S. Hughes M. D. or other
Address Hobart Date signed June 29

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

PLACE OF DEATH MEANS WHERE PERSON ACTUALLY DIED, NOT WHERE LIVED

EMBALMER'S NAME German Plushaupt LICENSE NO. 1833
FUNERAL DIRECTOR'S LICENSE NO. 373