

INDIANA STATE BOARD OF HEALTH

Division of Vital Records

CERTIFICATE OF DEATH

Local No. B-4-50
Death No. 2578

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

EMERALD'S NAME Herman Blumhaff
LICENSE No. 1833
FUNERAL DIRECTOR'S LICENSE No. 503

1. PLACE OF DEATH a. COUNTY <u>Porter 564</u>		9. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Lake</u>	
b. CITY OR TOWN <u>Valparaiso</u>		c. CITY OR TOWN <u>Rural</u>	
c. LENGTH OF STAY (in this place) <u>45 days</u>		d. STREET ADDRESS (If rural, give location) <u>Gray Route # 1 Ind.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Porter Memorial Hospital</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>8-6 1950</u>	
3. NAME OF DECEASED (Type or P) (First) <u>Amelia</u> (Middle) <u>Lenburg</u> (Last) <u>Anderson</u>		8. DATE OF BIRTH <u>Jan 18-1879</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	9. AGE (In years) <u>71</u> If under 1 year: Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife of Home</u>		11. BIRTHPLACE (State or foreign country) <u>Porter County Ind</u>	
13. FATHER'S NAME <u>John Lenburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Koppelman</u>	
16. SOCIAL SECURITY No. <u>731A-999-_____</u>		17. INFORMANT (NAME AND ADDRESS) <u>Edward A. Anderson, Gray Road Route 1</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: <u>Pathological fracture of femur</u> ANTECEDENT CAUSES: <u>Paget's Disease</u> Morbidity conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. <u>DUE TO Acute Heart failure</u> II. OTHER SIGNIFICANT CONDITIONS: <u>731A-999-_____</u> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21e. INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work at Work		21f. HOW DID INJURY OCCUR?	
22a. ATTENDING PHYSICIAN I certify that I attended the deceased from <u>8/2 1950</u> to <u>8-6 1950</u> and that death occurred at <u>5:20 PM</u> from causes stated and on above date.		22b. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ M from causes stated and on above date.	
23a. Signature of Attending Physician or Health Officer <u>E. G. ...</u>		23b. ADDRESS	
23c. DATE SIGNED			
24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/9/50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>McCool Cem</u>		24d. LOCATION <u>McCool Ind</u>	
DATE REC'D BY LOCAL HEALTH OFFICER <u>8-10-50</u>		SIGNATURE OF HEALTH OFFICER <u>C. H. Dewitt MD</u>	
25. FUNERAL DIRECTOR <u>Herman Blumhaff</u>		ADDRESS <u>Notat Ind</u>	

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