DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INDIANA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Local No. 25 1
Registered No. 17480

1. PLACE OF DEATH:
County Porter
City or town Gary ton, Ind.
(If outside city or town limits, write RURAL)
Street address, hospital, or institution: Gary R.R. 1
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 Ind. County Porter
City or town Gary ton, Ind
(If outside city or town limits, write RURAL)
Street No. Gary R.R. 1
(If rural give LOCATION)
2. (a) IF VETERAN, NAME WAR

3. (a) FULL NAME John H. Lenburg
3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M.	W.	Widowed

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

7. Birth date of deceased (mo., day, yr.) Oct 18, 1856

8. AGE: Years	Months	Days	If less than one day
83	7	4	hrs. ____ min.

9. Birthplace Valparaiso, Ind.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Retired

FATHER
12. Name Jacob Lenburg
13. Birthplace Germany

MOTHER
14. Maiden name Anna Shneddle
15. Birthplace Germany

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/25/40 (month) (day) (year)
Cemetery or crematory Mc Cool
Location Mc Cool, Ind.
18. Funeral director Williams & Burns
Address Gary, Ind.

Filed 5-24, 1940 [illegible] Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 20 1940, to May 22 1940, and that I last saw h[illegible] alive on May 20 1940

Immediate cause of death Carcinoma of Stomach

DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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

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 W. R. Stover M. D.
M. D. or other
Address Hobart, Ind. Date signed May 23