CERTIFICATE OF DEATH

FLORIDA

STATE FILE NO.

BIRTH NO.

REGISTRAR'S NO. 476

1. PLACE OF DEATH a. COUNTY: Dade	CODE NO. 23-10	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE: Indiana b. COUNTY: Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL): Miami	c. LENGTH OF STAY (in this place): 23 days	c. CITY OR TOWN (If outside corporate limits, write RURAL): Gary
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jackson Memorial Hospital		d. STREET ADDRESS (If rural, give location): 4000 Marshall Street

3. NAME OF DECEASED (Type or Print)	a. (First) MABEL	b. (Middle)	c. (Last) KOBE	4. DATE OF DEATH (Month) (Day) (Year)	Jan. 29, 1954			
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Jan. 17, 1914	9. AGE (In years last birthday): 40	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): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own house	11. BIRTHPLACE (State or foreign country): WISCONSIN	12. CITIZEN OF WHAT COUNTRY?: USA					
13. FATHER'S NAME: Fred Arts		14. MOTHER'S MAIDEN NAME: Unobtainable						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE: [signature] ADDRESS: 2046 W. Flagler Street					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	HEMOLYTIC STAPH MENINGITIS	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	SEPTICEMIA	30 DAYS
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	ACTIVE TUBERCULOSIS OF LUNG	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 0331-17	20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Probably) (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY OR TOWN) (COUNTY) (STATE) If rural, state RURAL	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 1/4/ 54, *to* 1/29/ 54, *that I last saw the deceased alive on* 1/29/ 1954, *and that death occurred at* 11:00AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): P. S. Howard M.D.	23b. ADDRESS: JACKSON MEMORIAL HOSPITAL	23c. DATE SIGNED: 1/30/54	
24a. BURIAL, CREMATION, REMOVAL (Specify): Removal	24b. DATE: 1-30-54	24c. NAME OF CEMETERY OR CREMATORY: Calvary	24d. LOCATION (City, town, or county) (State): Gary, Indiana
DATE REC'D BY LOCAL REG.: 1-30-54	REGISTRAR'S SIGNATURE: L. E. Colmore	25. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Tracy Funeral Home, Inc.	