

91008698

HO 45/348 LD (2)

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 2268-90

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) Wanda G. Beck		2. SEX Female	3a. TIME OF DEATH 6:10P. M	3b. DATE OF DEATH (Month, Day, Yr) November 7, 1990
4. SOCIAL SECURITY NUMBER 310-22-5149	5a. AGE—Last Birthday (Years) 86	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) July 28, 1904
7. BIRTHPLACE (City and State or Foreign Country) Mt. Victory, Ohio	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	

DECEDENT

9b. FACILITY NAME (If not institution, give street and number) 8733 Park Drive	9c. CITY, TOWN OR LOCATION OF DEATH Highland	9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) None	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Teacher
		12b. KIND OF BUSINESS/INDUSTRY School/Education

PARENTS

13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Highland	13d. STREET AND NUMBER 8733 Park Drive
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INFORMANT

13e. ZIP CODE 46322	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) White	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (11-4 yrs) 0
18. FATHER'S NAME (First, Middle, Last) William H. Baldwin			19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Catherine Reeve			

DISPOSITION

20a. INFORMANT'S NAME (Type/Print) Sheila White	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3047 Porter St. N.W. Washington DC20008	20c. Relationship Daughter
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21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Removal from Site	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 11, 1990 Wood Lawn Cemetery Gardens	21c. LOCATION—City or Town, State Ada, Ohio
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22a. EMBALMERS NAME Edgar Gleim	22b. EMBALMERS LICENSE NO. FDO1016173	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
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24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>	24b. LICENSE NUMBER (of License) FDO1014511	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home EDH3007500 9039 Kleinman RD. Highland, IN 46322
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CAUSE OF DEATH

26. PART I. IMMEDIATE CAUSE (Final disease or condition resulting in death) HEALTH DEPT. CAROTID JUNCT ANEURYSM WITH LIVER METASTASES	26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. FEB 22 1991	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A
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CERTIFIER

29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.	29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD	29c. MEDICAL LICENSE NO. 01018528	29d. DATE SIGNED (Month, Day, Year) 11-9-90
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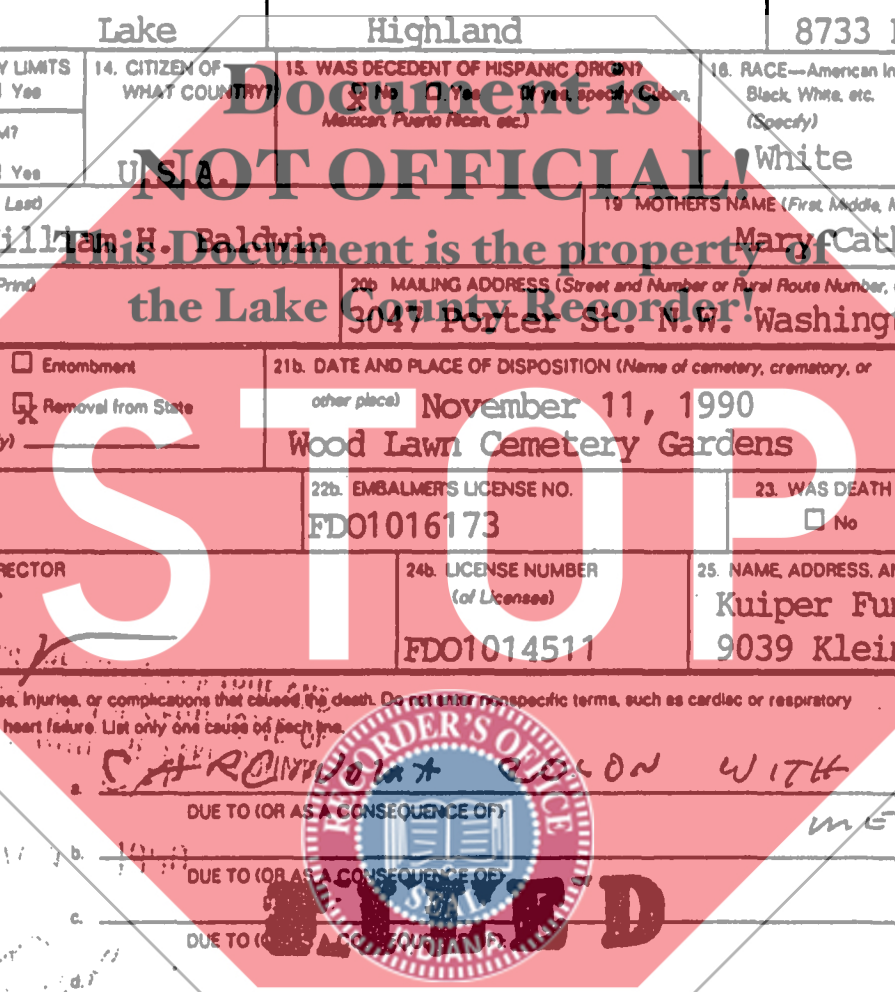
HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) W J FITZPATRICK 110 RIDGE RD MUNSTER IN 46321	31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>	32. DATE FILED (Month, Day, Year) Nov. 9, 1990
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CORONER USE ONLY

33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

LOT 19, Highland Park Manor and Add N Plat Book 28/67 #27-198-19



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