

ATTENTION STATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 275

CERTIFICATE OF DEATH

SI July 12, 1995 *Franklin D. Pennington, M.D.*
Date Issued Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) Carl A. Barr		2 SEX Male	3a TIME OF DEATH 3:00 a.m.	3b DATE OF DEATH (Month, Day, Year) April 10, 1995
4 SOCIAL SECURITY NUMBER 306-03-4587	5a AGE—Last Birthday (Years) 83	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hour Minutes	6 DATE OF BIRTH (Mo, Day, Yr) October 5, 1911
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	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) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy Hospital, Hammond		9c CITY, TOWN, OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mildred M. Bard	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Milkman	12b KIND OF BUSINESS/INDUSTRY Dairy	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 6720 Missouri Avenue	
13e ZIP CODE 46323	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 checked="" 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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) Arvid Barr		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Eva Heffernan		20a INFORMANT'S NAME (Type/Print) Mrs. Mildred Barr		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6720 Missouri Ave., Hammond, IN 46323		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b PLACE OF DISPOSITION (Name, address, city, state, zip code, or other place) Oak Hill Cemetery, Hammond, Indiana		21c LOCATION—City, State Hammond, Indiana
22a EMBALMER'S NAME George J. Johnson		22b EMBALMER'S LICENSE NO. .0890006	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer, Jr.</i>		24b LICENSE NUMBER (of License) 1006049	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home-3002869 7051 Kennedy, Hammond, IN 46323	
26 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe Coronary artery and Valve Disease Tamponade cerebral artery, accident		26 PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I.		
27 IMMEDIATE CAUSE (Final disease or condition resulting in death)		27a WAS AN AUTOPSY PERFORMED? (Yes or no) No		
27b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		27c WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		
28a CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		28b CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.		
28c SIGNATURE AND TITLE OF CERTIFIER <i>James Greenwald, M.D.</i>		28d MEDICAL LICENSE NO. 20603	28e DATE SIGNED (Month, Day, Year) April 10, 1995	
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) J. Greenwald, M. D., 222 Douglas Street, Hammond, Indiana 46320		30 DATE FILED (Month, Day, Year) APR 11 1995		
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Pennington, M.D.</i>		32 DATE FILED (Month, Day, Year) APR 11 1995		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		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.		34i		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

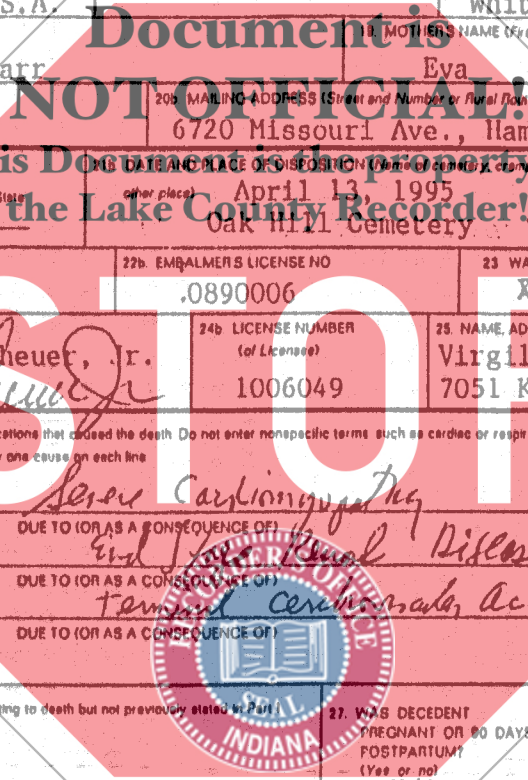
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

*copy of 9 BLS
copy of 10 BLS
Mary*

35-24-9



FILED

SEP 29 1995

**SAM ORLICH
AUDITOR LAKE COUNTY**

95058982

95 SEP 29 PM 1:52

**STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD**

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