

INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
CORONER'S CERTIFICATE OF DEATH

64-003656
Death No.

Local No. 65

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

Below for State Office Use.

3871

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EMBALMER'S NAME FRANK BERHEIDE
LICENSE NO. 447

FUNERAL DIRECTOR'S LICENSE NO. 316

1. PLACE OF DEATH a. COUNTY <u>Wayne</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Jay</u>	
b. CITY, TOWN, OR LOCATION <u>Rural</u>		c. Length of Stay in It	e. CITY, TOWN OR LOCATION <u>Dunkirk</u>
d. NAME OF HOSPITAL OR INSTITUTION <u>Richmond State Hospital</u>		d. STREET ADDRESS <u>Ohio St.</u>	
a. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Lida</u>		First	Middle
		Last	DATE OF DEATH <u>Jan. 28 1964</u>
5. SEX <u>Female</u>	8. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE OF BIRTH <u>Sept. 3, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u>
11. BIRTHPLACE (State or foreign country) <u>Bath Co., Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joe Max McLaughlin</u>		14. MOTHER'S MAIDEN NAME <u>Unk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk</u>		17a. INFORMANT'S NAME	
17b. INFORMANT'S ADDRESS <u>The Richmond State Hospital Medical Records, Richmond, Indiana</u>		17c. RELATIONSHIP TO DECEASED	

15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
DUE TO (b) <u>Fracture of Left Femur</u>		
DUE TO (c) <u>Generalized arteriosclerosis</u>		10 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 15.) <u>Patient fell from his chair in the hospital and fractured her left femur</u>	
20c. TIME OF INJURY <u>3:45 PM 11-10-63</u>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Eastern State Hospital</u>	20e. CITY, TOWN, OR LOCATION <u>Richmond</u>
20f. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20g. COUNTY <u>Wayne</u>	20h. STATE <u>Ind.</u>
21. I hereby certify that I took charge of the remains described above, had an inquest, autopsy, inquiry thereon and from evidence obtained had that said deceased came to her death from causes stated and at <u>11:55 AM</u> (E. S. T.) on the above date.		
22. Signature <u>Raymond H. Stegall, M.D.</u> (Coroner)		Address <u>264 17th Richmond Ind.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Int. S. H.</u>		23b. DATE <u>1-30-64</u>
23c. NAME OF CEMETERY OR CREMATORY <u>JONES CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BATH CO. KY.</u>
DATE REC'D BY LOCAL HEALTH OFFICER		24. FUNERAL DIRECTOR <u>STEGALL-BERHEIDE-ORR</u>
SIGNATURE OF HEALTH OFFICER <u>Francis B. Warrick, MD</u>		ADDRESS <u>222 N 10th St. Richmond, Ind.</u>