

THE DIVISION OF HEALTH OF INDIANA  
STANDARD CERTIFICATE OF DEATH

State File No. **30330**  
**7296**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. <b>7296</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Indiana</b> b. COUNTY <b>Vigo</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>Terre Haute</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>2308 Dillmon</b> <b>8130</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Carolyn</b>			b. (Middle) <b>E.</b>		c. (Last) <b>Ping</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 25, 1953</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>Nov. 15, 1938</b>		9. AGE (In years last birthday) <b>14</b> If UNDER 1 YEAR Months _____ Days _____ If UNDER 1 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work ordinarily engaged in during working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Terre Haute, Ind. /</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Carl Ping</b>			13b. MOTHER'S MAIDEN NAME <b>Edith Wallace</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Carl Ping Terre Haute, Ind.</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myasthenia gravis</b>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <b>Infantile cerebral hemiplegia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>744.0</b>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <b>12/15, 1952, to 7/25, 1953</b> , that I last saw the deceased alive on <b>7/25, 1953</b> , and that death occurred at <b>3:20 p.m.</b> from the causes and on the date stated above.									
23a. SIGNATURE <b>Andrew B. Jones</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>3726 Washington</b>			23c. DATE SIGNED <b>7/25/53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>7-26-53</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>Terre Haute, Ind.</b>			
DATE REC'D BY LOCAL REG. <b>JUL 27 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington</b>				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *John J. Harris*  
Licensed Embalmer No. *4108*  
P. O. Address *Harris M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.