INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

Local No. _____ State No. '58 009490

1. PLACE OF DEATH
a. COUNTY: Owen
b. CITY, TOWN, OR LOCATION: Goshort
c. Length of Stay in 1b: 5 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Goshort Nursing Home
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [X] NO [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana
b. COUNTY: Monroe
c. CITY, TOWN, OR LOCATION: Ellettsville
d. STREET ADDRESS: Ellettsville
e. IS RESIDENCE INSIDE CITY LIMITS? YES [X] NO [ ]
f. IS RESIDENCE ON A FARM? YES [ ] NO [ ]

3. NAME OF DECEASED (Type or print): First: Alice Middle: Melissa Last: Stines

4. DATE OF DEATH: Month Day Year: March 24, 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: March 15, 1895

9. AGE (In years last birthday): 63

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): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Monroe County, Ind

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown (orphan)

14. MOTHER'S MAIDEN NAME: unknown (orphan)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

17a. INFORMANT'S NAME: Mr. Ralph Stines

17b. INFORMANT'S ADDRESS: Box # 32 Ellettsville, Indiana

17c. RELATIONSHIP TO DECEASED: Husband

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis	6 mo.
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b)	Bronchogenic Carcinoma	1 yr.
DUE TO (c)		

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 [ ] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. ATTENDING PHYSICIAN: I certify that I attended the deceased from July 1957 to Mar 24 1958 and last saw her/him alive on Mar 24, 1958. Death occurred at 5:20 P. M (C.S.T.) on the date stated above, and to the best of my knowledge, from the causes stated.

22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ M (C.S.T.) from causes stated and on above date.

23a. Signature of Attending Physician or Health Officer.: M. S. Brown M.D.

23b. ADDRESS: Spencer Ind

23c. DATE SIGNED: 3/26/58

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: March 26, 58

24c. NAME OF CEMETERY OR CREMATORY: Clanberoville Cemetery

24d. LOCATION: Spencer, Indiana

DATE REC'D BY LOCAL HEALTH OFFICER: 3-29-58

SIGNATURE OF HEALTH OFFICER: Wran E. Kay M.D.

25. FUNERAL DIRECTOR ADDRESS: Greene & Harrell Mortuary Bloomington, Ind.

EMBALMER'S NAME: Ina L. Hudson LICENSE No. 1508

FUNERAL DIRECTOR'S LICENSE No. 2095

S.B.H.—6-24-3—Revised 1955 U. S. Department Health, Education and Welfare. Form Approved Budget Bureau No.