INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1991-679 State No. 91-047781

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
GRACE MAY STINES	FEMALE	10:15PM	DECEMBER 26,1991

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day. Yr.)	7 BIRTHPLACE (City and State or Foreign Country)
	88			AUGUST 2,1903	CINCINNATI, OHIO

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
NONE		HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
517 WEST FOURTH STREET	BLOOMINGTON	MONROE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
WIDOWED		DESK CLERK	INDIANA UNIVERSITY

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	MONROE	BLOOMINGTON	517 WEST FOURTH STREET

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
47403	☒ No ☐ Yes	☒ No ☐ Yes	U S A.	☒ No ☐ Yes	WHITE	ELEMENTARY	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
RAYMOND ROBERT MILLS	GRACE MAY (GRAF) MILLS

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
ANNABELLE SOUTHERN	517 WEST FOURTH ST.BLOOMINGTON,IND.47403	DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	CLOVER HILL CEMETERY 12/30/91	HARRODSBURG, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
MAX L. HUDSON	FDO 1045087	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Max L. Hudson	FDO 1045087	ALLEN FUNERAL HOME,INC.FDH 8600416 3000 E. 3RD.ST.BLOOMINGTON,IND.47401

CAUSE OF DEATH

26 PART I Enter the diseases, 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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a	Carcinomatosis	3 MO.
DUE TO (OR AS A CONSEQUENCE OF) b	Carcinoma Ovary	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF) c		
d		

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I	27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	no	NO	

CERTIFIER

29a CERTIFIER (Check only one)
- ☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
- ☐ 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.
- ☐ 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	15241	12-30-91

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
PAUL W. HOLTZMAN, M.D. 809 WEST FIRST STREET BLOOMINGTON, INDIANA 47404

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
	December 30, 1991

CORONER USE ONLY

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

SBH06-004 **State Form 10110 (R2/3-89)** DEA CERT/PD 1