* **ATTENTION ESTATE:** The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2000-17 State No. 002470

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): HAROLD O. "PAT" STINES

2. SEX: MALE

3a. TIME OF DEATH: 1:25 A M

3b. DATE OF DEATH (Month, Day, Yr): JANUARY 9, 2000

5a. AGE—Last Birthday (Years): 79

5b. UNDER 1 YEAR: Months / Days

5c. UNDER 1 DAY: Hours / Minutes

6. DATE OF BIRTH (Mo, Day, Yr): AUG. 24, 1921

7. BIRTHPLACE (City and State or Foreign Country): ELLETTSVILLE, IN.

8a. WAS DECEDENT A U.S. VETERAN? YES

8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945

9a. PLACE OF DEATH (Check only one. See instructions): ☐ HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; ☒ OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number): RICHLAND BEAN BLOSSOM HEALTHCARE CENTER

9c. CITY, TOWN, OR LOCATION OF DEATH: ELLETTSVILLE

9d. COUNTY OF DEATH: MONROE

10. MARITAL STATUS (Specify): MARRIED

11. SURVIVING SPOUSE (If wife, give maiden name): BETTY MYERS

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ELECTRICIAN

12b. KIND OF BUSINESS/INDUSTRY: INDIANA UNIVERSITY

13a. RESIDENCE—STATE: INDIANA

13b. COUNTY: MONROE

13c. CITY, TOWN, OR LOCATION: ELLETTSVILLE

13d. STREET AND NUMBER: 7476 MUSTANG DRIVE

13e. ZIP CODE: 47429

13f. INSIDE CITY LIMITS: ☐ No ☒ Yes

13g. ON A FARM? ☒ No ☐ Yes

14. CITIZEN OF WHAT COUNTRY: USA

15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

16. RACE—American Indian, Black, White, etc. (Specify): WHITE

17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): RALPH STINES

19. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE HENDRICKS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): BETTY STINES

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7476 MUSTANG DR. ELLETTSVILLE, IN. 47429

20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Entombment ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JANUARY 11, 2000 VALHALLA MEMORY GARDENS

21c. LOCATION—City or Town, State: BLOOMINGTON, IN.

22a. EMBALMER'S NAME: DAVID W. GRANGER

22b. EMBALMER'S LICENSE NO: FD29800047

23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR: Arthur L. Sater

24b. LICENSE NUMBER (of Licensee): FD01008651

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ALLEN FUNERAL HOME FH#88600416 3000 E. THIRD ST. BLOOMINGTON, IN. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Alzheimers Dementia — DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. — DUE TO (OR AS A CONSEQUENCE OF)
c. — DUE TO (OR AS A CONSEQUENCE OF)
d.

Approximate Interval Between Onset and Death:

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): NO

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: 01048026

29d. DATE SIGNED (Month, Day, Year): 1/12/00 JAN 12, 2000

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MATTHEW CALDWELL M.D. 637 SOUTH WALKER ST. BLOOMINGTON, IN. 47403

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Thomas W Knapp MD

32. DATE FILED (Month, Day, Year): JAN 12 2000

33. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.