Indiana State Board of Health

CERTIFICATE OF DEATH 30605

Registered No.

1 PLACE OF DEATH

PUNCHED

County of Monroe

Township of Richland

Town of Ellettsville

or

City of ..... (No. ....., ... St.; ..... Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

[If death occurred in a Hospital or Institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Wm. Stines

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6a NAME OF HUSBAND OR WIFE (of deceased): Alice Stines

6 DATE OF BIRTH (of deceased): Feb. (Month) 13 (Day) 1855 (Year)

7 AGE: 68 years, 6 months, 28 days. If LESS than 1 day, ... hrs. or ..... min ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE OF DECEASED (State or country): Indiana

PARENTS

10 NAME OF FATHER: Jones Stines

11 BIRTHPLACE OF FATHER (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Nancy Parks

13 BIRTHPLACE OF MOTHER (State or country): South Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Stines

(Address) Ellettsville Ind.

15 Filed Sept 13, 1923

C F Rogers

Name and Address of Health Officer or Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 11 (Day) 1923 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 5 1923 to Sept 11 1923 that I last saw him alive on Sept 11 1923 and that death occurred, on the date stated above, at 12.30 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory 64

(SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. O. K. Harris, M. D.

Sept. 12, 1923. (Address) Ellettsville, Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or Usual Residence

19 PLACE OF BURIAL OR REMOVAL: Chambersville Cem.

DATE OF BURIAL: Sept. 3 1923

20 UNDERTAKER: Allen & Allen

WAS THE BODY EMBALMED? Yes

21 ADDRESS: Bloomington

EMBALMER'S LICENSE No. 2346