

84-041341

# INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

Local No. 1984-533

State No. \_\_\_\_\_

EMBALMER'S NAME.....TERRY L. DAVIDSON  
FUNERAL DIRECTOR'S SIGNATURE *Max S. Hurdson*  
LICENSE No. ....1573  
FUNERAL HOME No. ....41  
FUNERAL DIRECTOR'S LICENSE No. ....2035

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK	DECEASED—NAME 1 <b>RALPH S. STINES</b>			SEX 2 <b>MALE</b>	DATE OF DEATH (MONTH DAY YEAR) 3 <b>NOV. 15, 1984</b>
	RACE (Type or print) (Specify) 4 <b>WHITE</b>	AGE—Last Birthday (Type) 5a <b>91</b>	UNDER 1 YEAR 5b MOS. DAYS	UNDER 1 DAY 5c HOURS MINS	DATE OF BIRTH (Mo. Day Yr.) 6 <b>DEC. 7, 1892</b>
DECEASED	CITY TOWN OR LOCATION OF DEATH 7b <b>BLOOMINGTON</b>		HOSPITAL OR OTHER INSTITUTION—Name (if not in name, give street and number) 7c <b>BLOOMINGTON HOSPITAL</b>		IF HOSP OR INST. indicate DOA OR Emer. Rm. treatment (Specify) 7d <b>INPATIENT</b>
	STATE OF BIRTH (if not in U.S.A. name country) 8 <b>INDIANA</b>	CITIZEN OF WHAT COUNTRY 9 <b>U.S.A.</b>	MARRIED NEVER MARRIED WIDOWED DIVORCED (Specify) 10 <b>MARRIED</b>	SURVIVING SPOUSE (if wife, give maiden name) 11 <b>GRACE (MILLS) STINES</b>	
USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION	RESIDENCE—STATE 15a <b>INDIANA</b>		COUNTY 15b <b>MONROE</b>	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a <b>RET. STONE MILL WORKER</b>	
	CITY TOWN OR LOCATION 15c <b>BLOOMINGTON</b>		KIND OF BUSINESS OR INDUSTRY 14b <b>STONE MILLS</b>		
STREET AND NUMBER 15d <b>517 WEST FOURTH STREET</b>			IS RESIDENCE ON A FARM? 15e <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		INSIDE CITY LIMITS (SPECIFY YES OR NO) 15f <b>YES</b>
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC. 15g <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>					
PARENTS	FATHER—NAME FIRST MIDDLE LAST 16 <b>JOSEPH STINES</b>			MOTHER—MAIDEN NAME FIRST MIDDLE LAST 17 <b>ALICE (KIPHART) STINES</b>	
	INFORMANT—NAME (Type or print) RELATIONSHIP 18a <b>GRACE STINES, WIFE</b>		MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP 18b <b>517 WEST FOURTH STREET BLOOMINGTON, INDIANA 47401</b>		
DISPOSITION	BURIAL CREMATION REMOVAL OTHER (Specify) 19a <b>BURIAL</b>		CEMETERY OR CREMATORY—FUNERAL HOME 19b <b>CHAMBERSVILLE CEMETERY</b>		LOCATION CITY OR TOWN STATE 19c <b>OWEN COUNTY, INDIANA</b>
	DATE (MONTH DAY YEAR) 20a <b>NOVEMBER 18, 1984</b>		FUNERAL HOME—NAME AND ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP 20b <b>ALLEN FUNERAL HOME, INC. 3000 E. 3RD. ST. BLOOMINGTON, IND.</b>		
M.D. OR D.O.	To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. 21a (Signature) <i>[Signature]</i>			DATE SIGNED (Mo. Day Yr.) 21b <b>11-16-84</b>	HOUR OF DEATH 21c <b>8:50 PM M</b>
	NAME OF ATTENDING PHYSICIAN (Type or print) 21d <b>PAUL W. HOLTZMAN, M.D.</b>			MAILING ADDRESS—PHYSICIAN 21e <b>809 WEST FIRST STREET BLOOMINGTON, INDIANA 47401</b>	
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST  CAUSE	HEALTH OFFICER—SIGNATURE <i>Thomas W. Shapma</i>			DATE RECEIVED BY LOCAL HEALTH OFFICER 22b <b>11-16-84</b>	
	23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I (a) <b>dehydration + malnutrition</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>arteriosclerosis</b> DUE TO OR AS A CONSEQUENCE OF (c) _____		Interval between onset and death <b>11 DAYS</b> Interval between onset and death Interval between onset and death		
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I list					AUTOPSY (Specify Yes or No) 24