

JAN 16 1952

THE DIVISION OF HEALTH OF THE STATE OF MICHIGAN
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **0093**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Michigan b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PORT HURON 8210	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 815 ST. CHAIR	
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA CITY Hosp			

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) EUGENE c. (Last) STINSON			4. DATE OF DEATH (Month) (Day) (Year) JAN-5-52		
5. SEX MALE	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH JAN-20-1951	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Flint Michigan	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME ROBERT STINSON		13b. MOTHER'S MAIDEN NAME ANN LATHAN		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Ann Stinson 8155th Clair Port Huron Mich	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Branchial Aneurysm DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 241X	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Reg M. Schuur		23b. ADDRESS 1300 Clair		23c. DATE SIGNED 2/5/52	
24a. DATE OF BURIAL OR CREMATION REMOVAL (Specify)		24b. DATE JAN-5-52		24c. NAME OF CEMETERY OR CREMATORY MALDEN	
24d. LOCATION (City, town, or county) (State)		MALDEN MS.			

DATE RECD. BY LOCAL REG. JAN 5 1952		REGISTRAR'S SIGNATURE J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schuur	
				ADDRESS 3125 Lafayette Av.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Jose Ballena

Licensed Embalmer No. 4014

P. O. Address 3125 Josephine

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.