

MARGIN RESERVED FOR BINDING

EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Form V. S. 1-A

DEPARTMENT OF COMMERCE
Bureau of the Census

COMMONWEALTH OF KENTUCKY
Department of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. **4639**
Registrar's No. **2435**

Registration District No. **1885** Primary Registration District No. **2435**

1. PLACE OF DEATH:
(a) County **Muhlenberg**
(b) City or town **Central City Ky**
(c) Name of hospital or institution:
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Ky** (b) County **Muhlenberg**
(c) City or town _____ (If outside city or town limits write RURAL)
(d) Street No. _____ (If rural give precinct)
(e) If foreign born, how long in U. S. A. ? _____ years

3(a) FULL NAME **Leatha Ewitts**
3(b) If veteran, Name war _____ 3(c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6(a) Single, widowed, married, divorced **Married**

5(b) Name of husband or wife **Eli Ewitts**

5(c) Age of husband or wife alive _____ Years _____ Months _____

7. Birth date of deceased **June 28 - 1907** (Month) (Day) (Year)

8. AGE **34** Years **7** Months **3** If less than one day _____ hr. _____ min.

9. Birthplace **Ky**

10. Usual occupation _____

11. Industry or business _____

FATHER
MOTHER

12. Name **Frank Wells**

13. Birthplace **Ky**

14. Maiden name **Ellean Kelley**

15. Birthplace **Ky**

16(a) Informant's own signature **Eli Ewitts**
(b) Address **Central City Ky**

17. BURIAL, CREMATION, OR REMOVAL **Blue Grove** Date **2-2** 19**42**

18(a) Signature of funeral director **W. B. Tucker**
(b) Address **Central City Ky**

19(a) **February 2, 1942** (Date received by local registrar) (b) **A. R. Blainhard** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH **2-7** 19**42**

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____, that I last saw him alive on _____ 19____, and that death occurred on the date stated above at **9:30 P.M.**

Immediate cause of death **Heart Dropsy**

Due to **Nephritis (Chronic)**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **Of operations**

Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? **at home** in or about home, on farm, in industrial place or in public place? (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **J. B. Tucker** (M.D. or other) **Car**

Address **Central City Ky** Date signed **2-1-42**