

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS 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. \_\_\_\_\_

Registrar's

23161

Registration District No. 1085 Primary Registration District No. 7471

1. PLACE OF DEATH:  
(a) County Muhlenberg  
(b) City or town Wesley Ky R #1  
(c) Name of hospital or institution:  
(If outside city or town limits, write RURAL)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Ky (b) County Muhlenberg  
(c) City or town Wesley  
(If outside city or town limits, write RURAL)

(If not in hospital or institution write street number or location)  
(d) Length of stay: In hospital or community \_\_\_\_\_  
(years, months or days)

(d) Street No. Wesley (If rural, give precincts)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3(a) FULL NAME Minnie Graves

3(b) If veteran, \_\_\_\_\_ 3(c) Social Security No. \_\_\_\_\_  
Name war \_\_\_\_\_

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

6(b) Name of husband or wife \_\_\_\_\_

6(c) Age of husband or wife if alive \_\_\_\_\_ Years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Year 65 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ky

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER { 12. Name John Andy Williams

13. Birthplace Ky

MOTHER { 14. Maiden name Fannie Stanley

15. Birthplace Ky

16(a) Informant's own signature Albert Graves

(b) Address Wesley Ky R #1

17. BURIAL, CREMATION, OR REMOVAL  
Place Wesley Date Oct 14 1943

18(a) Signature of funeral director Greenwell Funeral Home

(b) Address Greenwell, Ky.

19(a) 10-22-43 (Date received by local registrar) (b) Jane R. Louice (Registrar's signature)

20. DATE OF DEATH Oct 17 1943

21. I hereby certify that I attended the deceased from Oct 1 1943 to Oct 17 1943, that I last saw him alive on Oct 14 1943, and that death occurred on the date stated above at 9:20 P. M.

Immediate cause of death Tuberculosis of Primary Bronchi DURATION 6 mos

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations 20

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? In or about home, on farm, in industrial place, in public place? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Charles W. Greenwell M.D. (M. D. or other)

Address Greenwell Ky Date signed 10/21/43