FORM V.S. NO. T-A
REV. 1-56
FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
NATIONAL OFFICE VITAL STATISTICS

COMMONWEALTH OF KENTUCKY

DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF DEATH

FILE NO. 116 61 10869

REGISTRAR'S NO. 98

Registration District No. 1085 Primary Registration District No. 2435

1. PLACE OF DEATH
a. COUNTY: Muhlenberg
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Central City, Ky.
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Fourth St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Ky.
b. COUNTY: Muhlenberg
c. CITY OR TOWN: Central City
IS RESIDENCE ON A FARM? YES ☐ NO ☒
d. STREET ADDRESS: S. Fourth St.
IS RESIDENCE INSIDE CITY LIMITS? YES ☒ NO ☐

3. NAME OF DECEASED (Type or Print): a. (First) Annie b. (Middle) I. c. (Last) Heck

4. DATE OF DEATH (Month) (Day) (Year): 5/14/1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 10/16/1873

9. AGE (In years last birthday): 87
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ky.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: W. H. Smith

14. MOTHER'S MAIDEN NAME: Isadora Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Louise Roll

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial pneumonia & Senility
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 491 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

21a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.):

21b. TIME OF INJURY Hour a. m. p. m. Month, Day, Year:

21c. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21e. CITY, TOWN, OR LOCATION COUNTY STATE

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* 5:15 A. m., *from the causes and on the date stated above.*

23a. DATE SIGNED:

23b. ADDRESS: Central City, Ky

23c. SIGNATURE (Degree or title): F. L. Nabors M.D

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 5/15/61

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill

24d. LOCATION (City, town, or county) (State): Central City, Ky.

25a. DATE REC'D BY LOCAL REG.: 5-10-61

25b. REGISTRAR'S SIGNATURE: Margarie Hodge

26. FUNERAL DIRECTOR ADDRESS: Tucker Funeral Home Central City, Ky.