

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

State File No.

24715

Registrar's No.

310

CERTIFICATE OF DEATH

Registration District No. 7085

Primary Registration District No. 2436

1. PLACE OF DEATH:

(a) County Muhlenberg
(b) City or town Greenfield
(If outside city or town limits, write RURAL)
(c) Name of hospital or institution:
Greenfield Hospital
(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 Muhl
(c) City or town Central City
(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 Billy Warren Hendricks

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

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

6(b) Name of husband or wife _____

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

7. Birth date of deceased Oct 10 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 7
If less than one day _____ hr. _____ min.

9. Birthplace Ky

10. Usual occupation _____

11. Industry or business _____

FATHER { 12. Name Edward R. Hendricks

13. Birthplace Ky

MOTHER { 14. Maiden name Clarie Hardison

15. Birthplace Ky

16(a) Informant's own signature E. P. Hendricks

(b) Address Central City, Ky

17. BURIAL, CREMATION, OR REMOVAL
Place Fairmount Date 10-18 1946

18(a) Signature of funeral director Zucker's Funeral Home

(b) Address Central City, Ky

19. November 5, 1946 (Date received by local registrar) James R. O'Blanchard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1946

21. I hereby certify that I attended the deceased from Oct. 10 1946
to Oct. 17 1946, that I last saw him alive on
Oct. 17 1946 and that death occurred on the date
stated above at 11:30 A. M.

Immediate cause of death Premature birth DURATION

Due to _____

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

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

23. Signature J. P. Wallin M.D.
(M. D. or other)

Address Central City, Ky Date signed Nov. 5-46