

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

DELAY

COMMONWEALTH OF KENTUCKY

 Walton
 Issue No. 19342
 Registrar's No. 211

 FEDERAL SECURITY AGENCY
 U. S. PUBLIC HEALTH SERVICE
 NATIONAL OFFICE VITAL STATISTICS

 Department of Health
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 1085 Primary Registration District No. 7471

1. PLACE OF DEATH:		2. USUAL RESIDENCE OF DECEASED:	
(a) County <u>Woolverton</u>	(a) State <u>Ky</u>	(b) County <u>Mull.</u>	(c) City or town <u>Bremen Ky</u>
(b) City or town <u>Bremen Ky</u>	(If outside city or town limits, write RURAL)		
(c) Name of hospital or institution:	(d) Street No.	(If rural give precinct)	
(If not in hospital or institution write street number or location)	(e) If foreign born, how long in U. S. A? _____ years		
(d) Length of stay: In hospital or community _____ (years, months or days)			
3(a) FULL NAME <u>Charles Thomas Miller</u>			
3(b) If veteran, Name war _____		3(c) Social Security No. _____	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6(a) Single, widowed, married, divorced <u>Married</u>	
6(b) Name of husband or wife <u>Ollie Deftter</u>		6(c) Age of husband or wife if alive _____ years	
7. Birth date of deceased <u>Nov 4 - 1868</u> (Month) (Day) (Year)			
8. AGE: <u>79</u> Year <u>2</u> Month <u>2</u> Day		If less than one day hr. min.	
9. Birthplace <u>Ky</u>			
10. Usual occupation _____			
11. Industry or business _____			
FATHER	12. Name <u>Daniel B. Miller</u>		
	13. Birthplace <u>Ky</u>		
MOTHER	14. Maiden name <u>Mary Katherine Stewart</u>		
	15. Birthplace <u>Ky</u>		
16(a) Informant's own signature <u>Tom Miller</u>			
(b) Address <u>Bremen Ky</u>			
17. BURIAL, CREMATION, OR REMOVAL <u>Brae Creek</u> Date <u>Aug 8, 1948</u>			
18(a) Signature of funeral director <u>James J. ...</u>			
(b) Address <u>Central City, Ky</u>			
19(a) <u>9-1-1948</u> (Date received by local registrar) <u>...</u> (Registrar's signature)			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Aug 6</u> 19 <u>48</u>			
21. I hereby certify that I attended the deceased from <u>June 1</u> 19 <u>48</u> to <u>Aug 1</u> 19 <u>48</u> , that I last saw him alive on <u>Aug 1</u> 19 <u>48</u> and that death occurred on the date stated above at <u>S. P. M.</u>			
Immediate cause of death <u>apoplexy</u>			DURATION
Due to <u>Hypertension</u>			
Other conditions _____ (Include pregnancy within 3 months of death)			
Major findings: <u>83A-102</u>			
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? _____ (e) Means of injury _____			
23. Signature <u>J. P. Walter Miller</u> (M. D. or other)			
Address <u>Central City, Ky</u> Date signed <u>Aug 21-48</u>			