

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. R. 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. 27049

Registrar's No. 283

Registration District No. 1082

Primary Registration District No. 7471

1. PLACE OF DEATH:

(a) County Mitchell  
(b) City or town Frankfort Ky  
(If outside city or town limits, write RURAL)  
(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 Mitchell  
(c) City or town Frankfort Ky  
(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 Charles Deas Mitchell

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

4. Sex Male 5. Color White 6(a) Single, widowed, married, divorced W

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

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

7. Birth date of deceased April 28 - 1858 Years  
(Month) (Day) (Year)

8. AGE: 87 Months 10 Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_

9. Birthplace Hopkins Co., Ky.

10. Usual occupation Farmer

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

FATHER { 12. Name Louison Mitchell  
13. Birthplace N.C.

MOTHER { 14. Maiden name Marian Hill  
15. Birthplace Ky

16(a) Informant's own signature Ernest Deas Mitchell

(b) Address Central City, Ky.

17. BURIAL, CREMATION, OR REMOVAL

Place None Date Dec 7, 1945

18(a) Signature of funeral director Tucker Funeral Home

(b) Address Central City, Ky

19(a) December 10, 1945 (Date received by local registrar)  
(b) Anna B. Blalock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7, 1945

21. I hereby certify that I attended the deceased from Dec 7, 1945 to Dec 7, 1945 that I last saw him alive on Dec 7, 1945 and that death occurred on the date stated above at 11:40 AM M.

Immediate cause of death Coronary thrombosis

Due to Pruritus

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? \_\_\_\_\_ (e) Means of Injury \_\_\_\_\_

23. Signature Dr. Harrison (M. D. or other)

Address Central City, Ky Date signed Dec 8, 1945