

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. 1-4

DEPARTMENT OF COMMERCE
Bureau of the Census

COMMONWEALTH OF KENTUCKY

Department of Health
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State File No. **2090**
Registrar's No. **31**

Registration District No. **1085** Primary Registration District No. **2436**

1. PLACE OF DEATH:

(a) County **Muhlenberg**
(b) City or town **Greenville**
(c) Name of hospital or institution
Muhlenberg Co. Community Hosp.
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or community **14**⁰¹
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ky.** (b) County **Muhlenberg**
(c) City or town _____
(If outside city or town limits, write RURAL)
(d) Street No. **207 West Main Cross St.**
(If rural give precinct)
(e) If foreign born, how long in U. S. A.? _____ years

3(a) FULL NAME **William Thomas Mitchell**

3(b) If veteran,
Name war _____

3(c) Social Security
No. _____

4. Sex **male** 5. Color or race **white** 6(a) Single, widowed, married, divorced **married**

6(b) Name of husband or wife **Ella S. Mitchell**

6(c) Age of husband or wife if alive **64** Years

7. Birth date of deceased **aug. 24 1878**
(Month) (Day) (Year)

8. AGE: Years **68** Months **4** Days **21**
If less than one day hr. _____ min.

9. Birthplace **Muhlenberg Co.**

10. Usual occupation **salesman of used** 5

11. Industry or business **mine supplies.**

FATHER { 12. Name **Robert Mitchell**

13. Birthplace **Muhlenberg Co.**

MOTHER { 14. Maiden name **Virginia Devine**

15. Birthplace **Muhlenberg Co.**

16(a) Informant's own signature **Wm L. Mitchell**

(b) Address **Greenville, Ky.**

17. BURIAL, CREMATION, OR REMOVAL
Place **Evergreen** Date **Jan 6 1947**

18(a) Signature of funeral director **J. Irvin Gary**

(b) Address **Greenville, Ky.**

19(a) **1-20-47** (Date received by local registrar)

(b) **Marjorie Hodge** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Jan. 14 1947**

21. I hereby certify that I attended the deceased from **1-1 1947**

to **1-14-47** 19____, that I last saw him alive on **1-14-47** 19____, and that death occurred on the date stated above at **8:50 P. M.**

Immediate cause of death

Shock, Post-operative

Reaction to Gall Colon

W. Co. of Colon

Hypertension (Essential)

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations **40E-92E**

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 **DD [Signature]** (M. D. or other)

Address **Bennett, Ky.** Date signed **1-14-47**