Form V. S. 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. 28330
Registrar's No. 397

Registration District No. 1085 Primary Registration District No. 2435

1. PLACE OF DEATH:
(a) County Muhlenberg
(b) City or town Central City 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 Muhl
(c) City or town ___ (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 James A Reed
3(b) If veteran, Name war ___ 3(c) Social Security No. ___
4. Sex M 5. Color or race W 6(a) Single, widowed, married, divorced W
6(b) Name of husband or wife ___
6(c) Age of husband or wife if alive ___ Years
7. Birth date of deceased Feb 20 - 1869 (Month) (Day) (Year)
8. AGE: Years 70 Months 9 Days 9 If less than one day ___ hr. ___ min.
9. Birthplace Ky.
10. Usual occupation Laborer
11. Industry or business ___
FATHER 12. Name Joke Reed
13. Birthplace Ky
MOTHER 14. Maiden name Mary Sallee
15. Birthplace Ky
16(a) Informant's own signature Mrs Henry Fitts
(b) Address Central City, Ky.
17. BURIAL, CREMATION, OR REMOVAL
Place Reed Cemetery Date 12-1 1939
18(a) Signature of funeral director Pickers Funeral Home
(b) Address Central City Ky.
19(a) December 1, 1939 (Date received by local registrar) (b) James Oates (Registrar's signature)
By A. L. Blandford, Deputy

MEDICAL CERTIFICATION
20. DATE OF DEATH 11-29 1939
21. I hereby certify that I attended the deceased from 1936 19___ to Nov. 29 1939 19___, that I last saw him alive on ___ 19___, and that death occurred on the date stated above at 11:30 P.M.
Immediate cause of death Pneumonia Bronchi
Due to Gastro Enteritis
Other conditions 120-107 (include pregnancy within 3 months of death)
DURATION
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 4642
23. Signature [illegible] (M. D. or other)
Address Central City Ky Date signed ___

N. B.—WRITE PLAINLY WITH PLEADING 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.