

Dr. Wyatt

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. 890
Registrar's No. 890

Registration District No. 500 Primary Registration District No. 2163

1. PLACE OF DEATH:
(a) County Fayette
(b) City or town Lexington
(If outside city or town limits, write RURAL)
(c) Name of hospital or institution:
Good Samaritan 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 Kentucky (b) County Fayette
(c) City or town Rural
(If outside city or town limits, write RURAL)
(d) Street No. Rosemont
(If rural give precinct)
(e) If foreign born, how long in U. S. A.? _____ years

3(a) FULL NAME Prof. McHenry Rhoads

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 Widower

6(b) Name of husband or wife Lee Crawford

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

7. Birth date of deceased July 27th, 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 5 20 hr. min.

9. Birthplace Muhlenberg Co. Ky.

10. Usual occupation Retired University

11. Industry or business Professor

FATHER { 12. Name Absalon Rhoads

13. Birthplace Ky.

MOTHER { 14. Maiden name Tabitha Rice Dennis

15. Birthplace Ky.

16(a) Informant's own signature Wayland Rhoads

(b) Address 1435 South Limestone St.

17. BURIAL, CREMATION, OR REMOVAL

Place Lexington Cemetery, Jan 18, 1943

18(a) Signature of funeral director W. R. Wilward

(b) Address Lexington Ky.

19(a) 1-29-43 (Date received by local registrar) (b) W. R. Wilward (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16th, 1943 1943

21. I hereby certify that I attended the deceased from Jan. 16, 1943 to Jan. 16, 1943 that I last saw him alive on Jan. 16, 1943 and that death occurred on the date stated above at 11:15 A. M.

Immediate cause of death thrombosis left vertebral + basilar arteries DURATION 16 days

Due to _____

Other conditions coronary heart disease, auricular fibrillation: bilateral carotid
(Include pregnancy within 3 months of death)

Major findings: thrombosis

Of operations _____

Of autopsy thrombosis left vertebral + basilar arteries; liquefactive necrosis, left cerebral hemisphere; coronary atherosclerosis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): _____

(b) Date of occurrence 1/18/43

(c) Where did injury occur? in or about home, on farm, in industrial plant, in public place? _____
(Specify type of place)

While at work? _____ (e) Means of Injury _____

23. Signature W. R. Wilward (M. D. or other)

Address Lexington, Ky. Date signed 1/28/43

N. B.—WRITE PLAINLY WITH 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.