

COMMONWEALTH OF KENTUCKY
Department of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. **2370**
Registrar's No. _____

Registration District No. **920** Primary Registration District No. **6811**

1. PLACE OF DEATH:
(a) County **Logan**
(b) City or town **Lewisburg Ky**
(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 **Kentucky** (b) County **Logan**
(c) City or town **Lewisburg 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 **Ruth Cornelious Sumner**

3(b) If veteran, _____ 3(c) Social Security
Name war _____ No. _____

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

6(b) Name of husband or wife _____

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

7. Birth date of deceased **April 25 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 8 30 hr. _____ min.

9. Birthplace **Mulenburg County**

10. Usual occupation **Housewife**

11. Industry or business _____

FATHER { 12. Name **George McPherson**

13. Birthplace **Mulenburg County**

MOTHER { 14. Maiden name **Susan Williams**

15. Birthplace **Mulenburg**

16(a) Informant's own signature **S.H. Petros**

(b) Address **Louisville Ky**

17. BURIAL, CREMATION, OR REMOVAL
Place **Summers Ky** Date **Jan 25, 1944**

18(a) Signature of funeral director **H.P. Hargrader**

(b) Address **Lewisburg Ky**

19(a) **Feb. 1 1944** (Date received by local registrar)

(b) **Stacy Hope Anderson** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH **Jan. 24 1944**

21. I hereby certify that I attended the deceased from **Jan 20 1944** to **Jan 29 1944**, that I last saw him alive on **Jan 24 1944** and that death occurred on the date stated above at _____ M.

Immediate cause of death **Embolic infarct**
and Sclerosis

DURATION

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major surgery:

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 **H.P. Hargrader M.D.** (M. D. or other)

Address **Lewisburg Ky** Date signed _____

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.

MARGIN RESERVED FOR BINDING