

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

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.

20296

Registrar's No.

245

Registration District No. 1085 Primary Registration District No. 7471

1. PLACE OF DEATH:

(a) County Muhlenberg
(b) City or town Rural Greenville
(If outside city or town limits, write RURAL)
(c) Name of hospital or institution:

2. USUAL RESIDENCE OF DECEASED:

(a) State Ky (b) County Muhlenberg
(c) City or town (Rural) Greenville
(If outside city or town limits, write RURAL)
(d) Street No. Main
(If rural give precinct)
(e) If foreign born, how long in U. S. A.? yes

(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or community _____
(year, months or days)

3(a) FULL NAME Ed Sweeney

3(b) If veteran, _____ 3(c) Social Security No. _____
Name war _____ 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 7 7 1872 Years
(Month) (Day) (Year)

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: 74 Months Days _____ If less than one day hr. _____ min.

9. Birthplace KY

10. Usual occupation Farmer

11. Industry or business _____

FATHER { 12. Name William Sweeney
13. Birthplace KY

MOTHER { 14. Maiden name Nancy Lukes
15. Birthplace KY

16(a) Informant's own signature Sidney Sweeney

(b) Address Kardmanville, KY

17. BURIAL, CREMATION, OR REMOVAL
Place James Date 7/20/46

18(a) Signature of funeral director Greenville Funeral

(b) Address Greenville Ky

19(a) 9-16-46 (Date received by local registrar) (b) Marjorie Haged (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946
21. I hereby certify that I attended the deceased from June 10 1946
to Aug 19 1946 that I last saw him alive on Aug 10 1946 and that death occurred on the date stated above at 11:25 A.M.

Immediate cause of death Chronic Arteriosclerotic DURATION 2 yrs
Due to _____
Other conditions General Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____
23a Signature Charles Wilson M.D. (M. D. or other)
Address Greenville Ky Date signed 9/14/46