23257

DELAY

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. ______
Registrar's No. 147

Registration District No. 640 Primary Registration District No. 5661

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

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

3(a) FULL NAME Allen Tress Taylor

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 Mary Daily

6(c) Age of husband or wife if alive 54 Years

7. Birth date of deceased June 8, 1888 (Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 16 If less than one day ___ hr. ___ min.

9. Birthplace Kentucky

10. Usual occupation Section Labor 4

11. Industry or business I. C. R.R.

FATHER 12. Name Samuel Taylor
13. Birthplace Kentucky

MOTHER 14. Maiden name Eliza Allen
15. Birthplace Kentucky

16(a) Informant's own signature Mrs Mary Taylor
(b) Address Cecilia, Kentucky

17. BURIAL, CREMATION, OR REMOVAL
Place Central City, Ky. Date 10/27 1945

18(a) Signature of funeral director [illegible] & Atwood
(b) Address Elizabethtown, Ky.

19(a) 11-6-1945 (Date received by local registrar) (b) Mrs Ethel [illegible] (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1945

21. I hereby certify that I attended the deceased from ______ 19__ to ______ 19__, that I last saw him alive on ______ 19__, and that death occurred on the date stated above at 1:30 A. M.

Immediate cause of death Coronary Occlusion — DURATION

Due to ______

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

Major findings:
Of operations ______ 94A
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 B W Perry Coroner H Co (M. D. or other)
Address Etown Date signed 10/24/45