

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

28098
 State File No. 314
 Registrar's No. 7471

Registration District No. 10 85 Primary Registration District No. 7471

1. PLACE OF DEATH

(a) County Muhlenberg Ky

(b) City or town Bremen 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 Earl Whitmer

3(b) If veteran, _____ 3(c) Social Security _____

Name of Mate White No. Married
(a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

4. Name of husband or wife _____

6(b) Name of husband or wife _____

6(c) Age of husband or wife if alive not 5-1894 Years

7. Birth date of deceased not 5-1894
(Month) (Day) (Year)

8. AGE: 49 2 19 Ky.
If less than one day or min.

9. Birthplace _____

10. Usual occupation Farmer.

11. Industry or business _____

FATHER { 12. Name Leop Whitmer

13. Birthplace Ky.

MOTHER { 14. Maiden name Emma Phillips

15. Birthplace Ky.

16(a) Informant's full signature Earl Whitmer

(b) Address Bremen Ky

17. BURIAL, CREMATION OR REMOVAL Brian Creek Date 12-26-43

18(a) Signature of funeral director Central City Ky

(b) Address _____

19(a) December 28, 1943 (Date received by local registrar)

Emma E. D. Dandridge (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1943

21. I hereby certify that I attended the deceased from May 30 1940 to Dec 24 1943, that I last saw him alive on Dec 24 1943, and that death occurred on the date stated above at Le P. M.

Immediate cause of death Pulmonary embolism

Due to Pulmonary tuberculosis

Other conditions Gravid uterus, tubercular calcifications
(Include pregnancy within 3 months of death)

Major findings: 13 D - X3A

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? _____ (a) Means of injury _____

23. Signature Dr. W. O. Mayfield (M. D. or other)
 Address Sacramento Ky Date signed 12/27/43