

Commonwealth of Kentucky  
STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH

County *Washington*

Vot. Prec. *Washington*

Ino. Town .....

City .....

2 FULL NAME *Anderson William*

CERTIFICATE OF DEATH

Registration District No. *7140*

Primary Registration District No. ....

(No. ....

St., .....

File No. ....

*29672*

*28*

Registered No. ....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH ..... 19*45*  
(Month) (Day) (Year)

7 AGE *66* yrs. .... mos. .... ds. IF LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Farming* (b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Tenn*

PARENTS

10 NAME OF FATHER *Wm*

11 BIRTHPLACE OF FATHER (State or country) *Don't know*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sam Bates*

(Address) *Graham*

15 Filed *1/15*, 19*45* Registrar *J. C. Keenum*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 14, 1945*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct 26, 1945* to *Nov 14, 1945* that I last saw him alive on *Nov 10, 1945*, and that death occurred on the date stated above at *1240 1/2* the CAUSE OF DEATH was as follows:

*Myocardial Infarction*

Contributory (SECONDARY) .....

(Duration) ... yrs. .... mos. .... ds.

(Signed) *T. J. Edger*, M. D.

*Nov 14, 1945* (Address) *Graham*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ... yrs. .... mos. .... ds. In the State ... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL *Mt Zion* DATE OF BURIAL *1945*

20 UNDERTAKER *Ed George* ADDRESS *Frankfort*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. B. E.--Every item of information should state CAUSE OF DEATH in terms, so that it may be properly OCCUPATION is very important. See instructions on back of certificate. MARGIN RESERVED FOR INDEXING