

Form C. R. 1-4

COMMONWEALTH OF KENTUCKY

State File No.

DEPARTMENT OF HEALTH
Bureau of the RegistrarDepartment of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registrar's No.

DELAY

Registration District No.

370

Primary Jurisdiction District No.

4541

1. PLACE OF DEATH:

(a) County Delay
 (b) City or town Chesnutburg
 (c) Outside city or town limits, write RURAL
 (d) Name of hospital or institution

(e) No. in hospital or institution write street number or location

(f) Length of stay in hospital or institution
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ky. (b) County Clay
 (c) City or town Chesnutburg rural
 (d) Outside city or town limits, write RURAL

(e) Street No. _____ (f) rural give postoffice

(g) If foreign born, how long in U. S. A. _____ years

3(a) FULL NAME Belle Delpha

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

Name was _____ sex _____

4. Sex Female 5. Color or race White 6(a) Single, widowed, married, divorced widowed6(b) Name of husband or wife John Bell6(c) Age of husband or wife if alive dead years

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

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ (hr) _____ (min)

9. Dialect Western Ky10. Usual occupation Housekeeper

11. Industry or business _____

12. Name ? Cordans

13. Birthplace _____

14. Mother name not known

15. Birthplace _____

16(a) Informant's own signature Laurel Roberts(b) Address Laurel Crest, Ky.

17. BURIAL, CREMATION, OR REMOVAL

Place Elks, Chesnutburg, Ky. Date 2-20, 1945

18(a) Signature of funeral director _____

(b) Address _____

19(a) 5-12-45

(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) _____

19 (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) _____

Registrar's Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20-45 194521. I hereby certify that I attended the deceased from birth to _____ 1945to _____ 1945 that I last saw him alive on _____ 1945, and that death occurred on the date

stated above at _____ (City or town)

Immediate cause of death Arteriosclerosis + stroke CURATION _____

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

Major findings _____

Of operations 112-16213

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? _____ (If "Yes" of injury)

23. Signature Richard S. Baker

(M. D. or other)

Address Manchester, Ky. Date signed May 9, 1945

MARGIN RESERVED FOR BINDING

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.