

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.

Form V. B. 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. 10304
Registrar's No. 98

Registration District No. 1085 Primary Registration District No. 2435

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Central City
(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 Kentucky (b) County Franklin
(c) City or town Central City
(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 William L. Campbell

3(b) If veteran, _____ 3(c) Social Security No. _____
Name war _____

4. Sex ma 5. Color or race w 6(a) Single, widowed, married, divorced married

6(b) Name of husband or wife _____

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

7. Birth date of deceased Sept 14 1860
(Month) (Day) (Year)

8. AGE: 83 Months 7 Day 1 If less than one day hr. _____ min. _____

9. Birthplace Phys

10. Usual occupation Photographer

11. Industry or business Photography

12. Name Thomas Campbell

13. Birthplace Ohio

14. Maiden name Sarah Baker

15. Birthplace Ohio

16(a) Informant's own signature W. L. Campbell

(b) Address Central City Ky.

17. BURIAL, CREMATION, OR REMOVAL
Place Crematorium Date 4-17-44

18(a) Signature of funeral director J. J. Anderson

(b) Address Central City Ky.

19(a) May 3 1944 (Date received by local registrar) (b) James A. Lovell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1944
21. I hereby certify that I attended the deceased from _____ 19____
to _____ 19____, that I last saw h. alive on _____ 19____

and that death occurred on the date stated above at 7:55 A. M.

Immediate cause of death Chronic Bronchitis DURATION: 2 week

Due to Arterio Sclerosis not known

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 5/2/44 107-97
2/15/44

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 J. J. Anderson (M. D. or other)

Address Central City Ky. Date signed 4-17-44