

MARGIN RESERVED FOR BINDING

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.

COMMONWEALTH OF KENTUCKY  
 Department of Health  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

State File No. 21035  
 Registrar's No. 248

Form V. B. 1-A  
 DEPARTMENT OF COMMERCE  
 Bureau of the Census

Registration District No. 1085 Primary Registration District No. 7471

1. PLACE OF DEATH  
 (a) County Muhlenberg  
 (b) City or town Central City Ky. R.H.  
 (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 Muhlenberg  
 (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 Effie Mae Goffinger  
 3(b) If veteran, \_\_\_\_\_ 3(c) Social Security \_\_\_\_\_  
 Name \_\_\_\_\_ No. \_\_\_\_\_  
 5. Color White 6(a) Single, widowed, married, divorced \_\_\_\_\_  
 6(b) Name of husband or wife James Goffinger  
 6(c) Age of husband or wife alive \_\_\_\_\_ Years  
 7. Birth date of deceased Jan 2 1873  
 (Month) (Day) (Year)  
 8. AGE: 31 Years 08 Months 11 Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Ky.  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 FATHER { 12. Name Riley Vincent  
 13. Birthplace \_\_\_\_\_  
 MOTHER { 14. Maiden name Mary Ellen Vincent  
 15. Birthplace \_\_\_\_\_  
 16(a) Informant's own signature James Goffinger  
 (b) Address Central City, Ky. R.H.  
 17. BURIAL, CREMATION, OR REMOVAL Cedar Grove Date Sept 15 1944  
 18(a) Sign of funeral director Funeral Home  
 (b) Address Central City, Ky.  
 19(a) 9-30-1944 (Date received by local registrar) James Goffinger (Registrar's signature)

20. DATE OF DEATH Sept 14 1944  
 21. I hereby certify that I attended the deceased from May 1943 to Sept 14 1944 that I last saw him alive on Sept. 12 P.M. and that death occurred on the date stated above at 2 P.M.  
 Immediate cause of death Sarcema  
 of James  
 DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: 55B  
 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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature J. P. Walton M.D. (M. D. or other)  
 Address Central City Ky Date signed 9-30-44