

FEDERAL SECURITY AGENCY  
U. S. PUBLIC HEALTH SERVICE  
NATIONAL OFFICE VITAL STATISTICS

Department of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Registrar's No. 257Registration District No. 1085 Primary Registration District No. 7471

1. PLACE OF DEATH a. COUNTY <u>Muhlenberg</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Ky</u> b. COUNTY <u>Muhlenberg</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>Nelson</u>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>Nelson</u>		d. STREET ADDRESS (If rural, give location)
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED a. (First) <u>Martha</u> b. (Middle)			c. (Last) <u>Reark</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 1-1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>Nov 18-1878</u>	9. AGE (In years last birthday) <u>77-10-13</u>	If Under Months 1 Year 1 Day 24 Hrs. 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ky.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Peter Buchanan</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Leneier</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>K. N. Reark</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic nephritis</u>	DUE TO (b) <u>Hypertensive Cardio-vascular disease</u>				
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) <u>592X-131A</u>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>Ventral hernia</u>				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Mar. 12, 1949</u> to <u>Sept 17, 1949</u> , that I last saw the deceased alive on <u>Sept. 12, 1949</u> and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.					
23a. DATE SIGNED <u>10/3/49</u>		23b. ADDRESS <u>Drakesboro, Ky.</u>		23c. SIGNATURE (Degree or title) <u>G. J. Proctor, M.D.</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-2-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riverside</u>	24d. LOCATION (City, town, or county) (State) <u>Muhlen Co. Ky.</u>		
25a. DATE REC'D BY <u>10-10-49</u>	25b. REGISTRAR'S SIGNATURE <u>Marjorie Hays</u>		25c. FUNERAL DIRECTOR <u>Jacks Funeral Home Central City</u>	ADDRESS	