Form V. S. 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. ____
Registrar's No. 25963

Registration District No. 325 Primary Registration District No. 42

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Hopkinsville (Rural)
(If outside city or town limits, write RURAL)
(c) Name of hospital or institution:
Western State Hospital
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or community 26 2 16
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kentucky (b) County Lyon
(c) City or town Eddyville
(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 Cal Stevens

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

4. Sex Male
5. Color or race Cau.
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 Mar. 2, (Month) (Day) 1869 (Year)

8. AGE: Years 73 Months 73 Days 9 3 If less than one day ____ hr. ____ min.

9. Birthplace Tennessee
10. Usual occupation Miner
11. Industry or business ____

FATHER
12. Name Joe Stevens
13. Birthplace Tennessee

MOTHER
14. Maiden name Ida Cochran
15. Birthplace Tennessee

16(a) Informant's own signature W.S.H. Records
(b) Address Hopkinsville, Ky.

17. BURIAL, CREMATION, OR REMOVAL
Place W S H Date 12-9, 1942
18(a) Signature of funeral director Custer Funeral Home
(b) Address W S H Hopkinsville Ky
19(a) 12-10-42 Catherine Hightower
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1942
21. I hereby certify that I attended the deceased from Sept. 19, 1916
to Dec. 5, 1942 that I last saw him alive on Dec. 5, 1942 and that death occurred on the date stated above at 7:00 P.M.

Immediate cause of death	DURATION
General Arteriosclerosis	
Due to	
Other conditions Psychosis	

(Include pregnancy within 3 months of death)

Major findings:
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 John C. Rogers M.D.
(M. D. or other)
Address Hopkinsville, Ky. Date signed 12/5/42
Western State Hospital

N. B.—WRITE PLAINLY WITH NON-FADING 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.

MARGIN RESERVED FOR BINDING