

MARGIN RESERVED FOR BINDING

COMMONWEALTH OF KENTUCKY

Department of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

22981

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

Registration District No. 1085 Primary Registration District No. 2405

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.

1. PLACE OF DEATH:  
(a) County Muhlenberg Ky  
(b) City or town Central City Ky  
(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 Muhl  
(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 Billy Roy Wilson  
3(b) If veteran, \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

Name war \_\_\_\_\_ No. \_\_\_\_\_  
4. Sex M 5. Color or race W 6(a) Single, widowed, married, divorced \_\_\_\_\_  
5(b) Name of husband or wife \_\_\_\_\_  
6(c) Age of husband or wife if alive \_\_\_\_\_ Years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)  
8. AGE: Years 11 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

7. Birthplace Kentucky  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

FATHER { 12. Name Roy Wilson  
13. Birthplace Ky  
MOTHER { 14. Maiden name Worthy Turner  
15. Birthplace Ky

16(a) Informant's own signature Roy W Wilson  
(b) Address \_\_\_\_\_

17. BURIAL, CREMATION, OR REMOVAL  
Place Nelson Creek Date 9-28, 1941

18(a) Signature of funeral director Tucker Funeral Home  
(b) Address Central City Ky

19(a) Sept 28, 1941 (Date received by local registrar) (b) A. L. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH Sept. 27 1941  
21. I hereby certify that I attended the deceased from Sept 20, 1941 to Sept 27 1941 that I last saw him alive on Sept 26 1941 and that death occurred on the date stated above at 1:00 P.M.

Immediate cause of death bronchial pneumonia (Primary) DURATION: 10 days  
Due to \_\_\_\_\_  
Other conditions (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 J. S. [Signature] (M. D. or other)  
Address Central City Ky Date signed 9/24-41