

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.

24564

Registrar's No.

928

Registration District No.

1085

Primary Registration District No.

2/35

1. PLACE OF DEATH:

(a) County Muhlenberg
(b) City or town Central City
(If outside city or town limits, write RURAL)
(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 Muhlenberg
(c) City or town Rural
(If outside city or town limits, write RURAL)
(d) Street No. _____
(If rural give precinct)
(e) If foreign born, how long in U. S. _____ years

3(a) FULL NAME

James T. Young

3(b) If veteran,

3(c) Social Security

Name war _____

No. _____

4. Sex

M

5. Color or race

W

6(a) Single, widowed, married, divorced

Single

6(b) Name of husband or wife _____

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

7. Birth date of deceased

May
(Month)24
(Day)1864
(Year)

8. AGE:

Years 75Months 8Days 20If less than one day
hr. _____ min. _____

9. Birthplace

Central City Ky

10. Usual occupation

Farmer

11. Industry or business _____

FATHER { 12. Name

Henry Young

13. Birthplace

Central City Ky

MOTHER { 14. Maiden name

Aliza Bruce

15. Birthplace

Ireland

16(a) Informant's own signature

Sheldon Young

(b) Address

Central City Ky

17. BURIAL, CREMATION, OR REMOVAL

Place

Central City

Date

9-15-1940

18(a) Signature of funeral director

J. G. Anderson

(b) Address

Central City Ky

19(a)

Oct. 5 1940

(Date received by local registrar)

(b)

James T. Young

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13th 1940
21. I hereby certify that I attended the deceased from Sept 12 1940
to Sept 13 1940, that I last saw him alive on
Sept 15 1940 and that death occurred on the date
stated above at 2:30 P. M.
Immediate cause of death fractured skullDURATION
24 h

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) Accidental
(b) Date of occurrence Sept 12 1940
(c) Where did injury occur? in or about home, on farm, in industrial place,
in public place? his farm
(Specify type of place)While at work? Yes

(e) Means of injury

fall from

23. Signature

J. H. Starnes

(M. D. or other)

Address

Central City Ky

Date signed

9-14-40

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.

MARGIN RESERVED FOR BINDING