VERIFICATION
NOT A CERTIFIED COPY

FORM VS-1B (Rev. 1/91)

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR HEALTH SERVICES
REGISTRAR OF VITAL STATISTICS

CERTIFICATE OF DEATH

116 ______ FILE NO. 36888

Registrar's No. ______

MUST BE TYPED

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Month, Day, Year)
JAMES WHEELER	MALE	12-21-96

4. SOCIAL SECURITY NO.	5a. AGE Last Birthday (Years)	5b. UNDER 1 YEAR (Months)	(Days)	5c. UNDER 1 DAY (Hours)	(Minutes)	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City/State or Foreign Country)
406-62-6858	75					10-06-21	UNKNOWN

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No): NO

9a. PLACE OF DEATH (Check only one)
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
VANCEBURG REG. HEALTH CARE	VANCEBURG	LEWIS

10. MARITAL STATUS (Married, Never Married, Widowed, Divorced (Specify))	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do Not use retired)	12b. KIND OF BUSINESS/INDUSTRY
UNKNOWN		FARM LABOR	FARMING

13a. RESIDENCE - State	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
KY	BATH	SALT LICK	678 McCARTY BRANCH RD.

13e. INSIDE CITY LIMITS? (Yes or No)	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE - American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elem/Secondary (0-12)	College (1-4 or 5+)
NO	40371	☒ No ☐ Yes	WHITE	N/A	

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
UNKNOWN	UNKNOWN

INFORMANT

19a. INFORMANT'S NAME	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NONE	

DISPOSITION

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - (City, Town or State)
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	JONES CEMETERY	SALT LICK, KY

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such)	22. NAME AND ADDRESS OF FACILITY
[signature] ROBERT J. POWELL	POWELL FUNERAL HOME P.O. BOX 294, SALT LICK, KY 40371

CERTIFIER

23a. To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Signature and Title: [signature] MD (MUST USE BLACK INK)
23b. DATE SIGNED (Month, Day, Year): 1/21/97

24. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28)
J.H. Black M.D. St. Claire HOspice 222 Medical Circle Morehead, Ky. 40351

25. TIME OF DEATH	26. DATE PRONOUNCED DEAD (Month, Day, Year)	27. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No)
6:15 _M	12/21/96	No

CAUSE OF DEATH

28. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

		Approximate interval between onset and death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Carcinoma of lung	5 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II Other significant conditions contributed to death but not resulting in the underlying cause given in Part I.	28a. WAS AUTOPSY PERFORMED? (Yes or No)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH (Yes or No)
Chronic obstructive airway Disease	No	

29. MANNER OF DEATH: ☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Could not be determined ☐ Homicide

30a. DATE OF INJURY (Month, Day, Year)	30b. TIME OF INJURY	30c. INJURY AT WORK? (Yes or No)	30d. DESCRIBE HOW INJURY OCCURRED.
	M		

30e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	30f. LOCATION (Street and number or Rural Route Number, City or Town)

REGISTRAR

31. REGISTRAR'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Barbara F. White	FEB 14 1997