

Registration District No. 50 Primary Registration District No. 4081

1. PLACE OF DEATH a. COUNTY <u>BATH</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions: residence before admission) a. STATE <u>KY</u> b. COUNTY <u>BATH</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SALT-LICK, KY</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>SALT-LICK, KY</u>	IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital of institution, give street address or location) <u>Midland</u>		d. STREET ADDRESS <u>Midland</u>	IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or Print) <u>BURNS, FRALEY</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY-17-1962</u>
--	------------	-------------	-----------	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC-29-1893</u>	9. AGE (To years last birthday) <u>68</u>	10. Under 1 Year <input type="checkbox"/>	11. Under 64 Mos. <input type="checkbox"/>	12. Under 64 Mos. <input type="checkbox"/>	13. Under 64 Mos. <input type="checkbox"/>
--------------------	-------------------------------	---	-------------------------------------	---	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CO. BARRACK</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	-----------------------------------	---	--

13. FATHER'S NAME <u>WILL-FRALEY</u>	14. MOTHER'S MAIDEN NAME <u>LIZZIE-PATRICK</u>
--------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>YES WAR-WW-1</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>JAMES FRALEY</u>
--	-------------------------	-----------------------------------

18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
4201 Conduction V. sup. which gave rise to above cause (a) placing the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	21a. DESCRIBE HOW INJURY OCCURRED (Under nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------------	----------------------------------	-----------------------------------	---	--

21b. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21d. PLACE OF INJURY (a. s., in, or about home, farm, factory, street, office bldg., etc.)	21e. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
---	--	--	------------------------------------	--------------	-------------

22. I hereby certify that I attended the deceased from 10 to 10, 1962, that I last saw the deceased alive on Monday May 17 1962 and that death occurred at 12:00 PM from the causes and on the date stated above.

23a. DATE SIGNED <u>5/18/62</u>	23b. ADDRESS <u>Owingsville, Ky.</u>	23c. SIGNATURE <u>Ray Anthony Regardy</u>
---------------------------------	--------------------------------------	---

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MAY-20-1962</u>	24c. NAME OF CEMETERY OR CREMATORY <u>JONES CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>(SALT-LICK, BATH KY)</u>
---	------------------------------	--	---

25a. DATE REC'D BY LOCAL REG. <u>5-21-1962</u>	25b. REGISTRAR'S SIGNATURE <u>Gene K. Brooks</u>	26. FUNERAL DIRECTOR <u>Bowling & Son</u>	ADDRESS <u>SALT-LICK, KY</u>
--	--	---	------------------------------

MEDICAL CERTIFICATION