

COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS  
CERTIFICATE OF DEATH

FILE NO. 116 **63** 13213  
REGISTRAR'S NO. **25**

Registration District No. **1310** Primary Registration District No. **8141**

1. PLACE OF DEATH a. COUNTY <b>Rowan</b>			2. USUAL RESIDENCE a. STATE <b>Kentucky</b>			b. COUNTY <b>Rowan</b>		
b. CITY (If outside corporate limits, write RURAL and give township) <b>Farmers</b>			c. LENGTH OF STAY (In this place) <b>20 yrs</b>			c. CITY OR TOWN <b>Farmers</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS			IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS			IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or Print) <b>Harry C. Adams</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 1, 1963</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1/18/84</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Year Months Days Hours Mins.	If Under 24 Hrs. Hours Mins.		
10a. USUAL OCCUPATION (Give kind of work, excluding most of working life, even if retired) <b>Merchant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>			11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		
12. CITIZEN OF <b>U S A</b>			13. FATHER'S NAME <b>Dook Adams</b>			14. MOTHER'S MAIDEN NAME <b>Ellen Adams</b>		
15. WAS DECEASED (Yes, no, or unknown) <b>No</b>	EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Maude Adams (Daughter)</b>					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> <i>Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____			MEDICAL CERTIFICATION <b>CVA</b>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	21a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
21b. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ A. M. P. M.								
21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (e. g., 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 <b>3-5, 1963</b> to <b>4-17, 1963</b> that I last saw the deceased alive on <b>4-17, 1963</b> , and that death occurred at <b>12 p.m.</b> , from the cause and on the date stated above.								
23a. DATE SIGNED <b>5-8-63</b>	23b. ADDRESS <b>Mt. Sterling, Ky.</b>			23c. SIGNATURE <b>Don E. Roberts M.D.</b>		(Print or Type Name)		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>5/3/63</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Jones Cemetery</b>			24d. LOCATION (City, town, or county) (State) <b>Bath County Kentucky</b>			
25a. DATE REC'D BY LOCAL REG. <b>5-10-63</b>	25b. REGISTRAR'S SIGNATURE <b>Dona Jean Cardill</b>			25c. FUNERAL DIRECTOR <b>Wm. H. Stuby</b>		ADDRESS <b>Morehead, Ky.</b>		

MEDICAL CERTIFICATION