

REG. 1-55  
 FEDERAL BUREAU OF INVESTIGATION  
 U. S. PUBLIC HEALTH SERVICE  
 NATIONAL OFFICE OF VITAL STATISTICS

 DEPARTMENT OF HEALTH  
 DIVISION OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

REGISTRAR'S NO. 3

Registration District No. 50 Primary Registration District No. 4081

1. PLACE OF DEATH a. COUNTY BATH		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE KY b. COUNTY BATH	
b. CITY (If outside corporate limits, write RURAL and give township) SALT-LICK		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		IS RESIDENCE IN CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) WILLIAM BLACK		4. DATE OF DEATH (Month) (Day) (Year) JAN 4, 1957	
a. (First) WILLIAM b. (Middle) BLACK c. (Last) BLACK			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APR 17 1890
9. USUAL OCCUPATION FARMER		10. KIND OF BUSINESS OR INDUSTRY II	
11. FATHER'S NAME WILLIAM - BLACK		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME BARBARA ELEN ALFREY		14. MOTHER'S MAIDEN NAME BARBARA ELEN ALFREY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT MRS. MALVA BLACK	

18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis pneumonia?		MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH 20+ yrs
DOE TO (b) Far advanced pulmonary tbc			
DOE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CC 2X-001-01		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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			21c. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. CITY, TOWN, OR LOCATION COUNTY STATE	

22. I hereby certify that I attended the deceased from 11-18, 1956 to death, 1957, that I last saw the deceased alive on 1-2, 1957, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

22a. DATE SIGNED 1-4-57	22b. ADDRESS Bowlingville Ky	22c. SIGNATURE (Degree or title) M.D. Johnson M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN 6-1957	23c. NAME OF CEMETERY OR CREMATORY JONES - CEM.
23d. DATE REC'D BY LOCAL REG. 1-6-1957	23e. REGISTRAR'S SIGNATURE Lena E. Brooks	23f. FUNERAL DIRECTOR (Firm or name) Swell & Son, Salt Lick Ky

MEDICAL CERTIFICATION