Form V. S. 1-A

Physician's CERTIFICATE OF DEATH

COMMONWEALTH OF KENTUCKY
Department of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15610

File No. V 695

Registered No. 695

Registration District No. 500

Primary Registration District No. 1462

1. Place of death: County FARMERS; City or Town Lexington KENTUCKY; Institution St Joseph Hospital

2. FULL NAME John Turner Myers

3. Residence: Bath Co. Ky (Usual place of abode); St. ; Ward (If unincorporated, give city or town and R.F.D.)

Length of residence in city or town where death occurred yrs mos ds; How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

4. SEX: MALE
5. COLOR OR RACE: WHITE
6. If married, widowed, or divorced: SINGLE
7. DATE OF BIRTH: Year ; Month ; Day ; Hour ; If LESS than 1 day, hours or minutes
8. AGE: Years 22 ; Months 11 ; Days ; Hours ; Minutes

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10. Kind of business or industry: Farming
11. Date last worked at this occupation: ; 12. Total time (years) spent in this occupation:

13. BIRTHPLACE: KENTUCKY

FATHER
14. NAME: Clarence Myers
15. BIRTHPLACE: KENTUCKY

MOTHER
16. MAIDEN NAME: Bertlett Adkins
17. BIRTHPLACE: KENTUCKY

18. INFORMANT: Ferrel Myers
Address: Morehead KENTUCKY

19. BURIAL, CREMATION, OR REMOVAL: Place Jones Cem. Date June 27 1937
20. UNDERTAKER: Barker & Hamerman
Address: Salt Lick KENTUCKY

21. FILED: 7/2 1937 D. Cox, Registrar

MEDICAL CERTIFICATE OF DEATH

22. DATE OF DEATH: June 24 1937

23. I HEREBY CERTIFY, That I attended deceased from December 19 1936 to June 24 1937
I last saw h[illegible] alive on December 19 1936 and to the best of my knowledge and belief death occurred on the date stated above, at 3:30 P. M.
The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
Terminal Pneumonia	
Duration collapse of left lung.	
Contributory causes of importance not related to terminal illness: Multiple Fractures of pelvis	

Name of operation: ; Date of:
What test confirmed diagnosis? Was there an autopsy? No

24. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? ; Date of injury: ; Where did injury occur? (Specify city or town, county, and state)

Specify whether injury occurred in industry, in home, or in public place: Corbin, Ky.

Nature of injury: Fractured pelvis and lower limb

Time of injury:

25. Was disease or injury in any way related to occupation of deceased? No If so, specify:

(Signed) Lloyd E. Hedden M. D.

(Address) St Joseph Hospital Lexington, Ky.

MARGIN RESERVED FOR BINDING

LOCAL INFORMATION IS A PERMANENT RECORD. CAUTION: Entries must be complete and accurate. Entry must be made in every space. Where the answer is "None," so state. Where unknown, make definite statement to that effect. Do not use ditto marks. Cross out words not necessary to be answered. Use black ink and write plainly. Do not fold.