

DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILE NO. 116

REGISTRAR'S NO.

1985

Registration District No. 500X Primary Registration District No. 2165

1. PLACE OF DEATH a. COUNTY <u>Layette</u>			2. USUAL RESIDENCE (Where deceased lived, if different residence before admission) a. STATE <u>Ky</u> b. COUNTY <u>Boyle</u>		
b. CITY (if outside corporate limits, write RURAL and OR TOWN <u>Lexington</u>)		c. LENGTH OF STAY (in this place) <u>01</u>	c. CITY OR TOWN <u>Saltlick, Ky</u>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Sam Hosp</u>			d. STREET ADDRESS <u>Rural</u>		
3. NAME OF DECEASED (Type or Print) <u>Thomas Everett H. Stemper</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 29, 1963</u>		
6. 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>July 13, 1918</u>		9. AGE (In years last birthday) <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Rowan Co., Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Stemper</u>			14. MOTHER'S MAIDEN NAME <u>Paul Gilbert</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>407-07-0570</u>		17. INFORMANT <u>Mrs. E. A. Stemper</u>	

18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u>
DUPLICATE COPY OF THIS SECTION TO BE FILED IN THE DEPARTMENT OF HEALTH, DIVISION OF VITAL STATISTICS, NATIONAL OFFICE, WASHINGTON, D. C.			DUPLICATE COPY OF THIS SECTION TO BE FILED IN THE LOCAL HEALTH DEPARTMENT, CITY OR TOWN OF DEATH.			?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN BY PART I (a) <u>Chronic Glomerulonephritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20. ACCIDENT SUICIDE HOMICIDE			21a. DESCRIBE THE 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. CITY, TOWN, OR LOCATION			COUNTY STATE
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 17 NOV, 1963 to 29 NOV, 1963 that I last saw the deceased alive on 29 NOV, 1963 and that death occurred at 6:15 p. m. from the causes and on the date stated above.

23a. DATE SIGNED <u>12-4-63</u>		23b. ADDRESS <u>Smyton, Ky</u>		23c. SIGNATURE (Approve or Sign) <u>C. E. Rankin MD</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/1/63</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Jones Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Boyle Co. Ky</u>
25a. DATE REC'D BY LOCAL REG. <u>12-6-63</u>		25b. REGISTRAR'S SIGNATURE <u>Flora Mae Coughlin C.D.</u>		25c. FUNERAL DIRECTOR ADDRESS <u>Lied Keel Owensville Ky</u>	

Keel Funeral Home

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