

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH PERMANENT INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Form V. B. 1-A

DEPARTMENT OF COMMERCE
Bureau of the Census

COMMONWEALTH OF KENTUCKY

Department of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No.

Registrar's No.

22802

74

Registration District No.

335

Primary Registration District No.

4711

1. PLACE OF DEATH:

(a) County

(b) City or town

(If outside city or town limits, write RURAL)

(c) Name of hospital or institution:

(If not in hospital or institution write street number or location)

(d) Length of stay: In hospital or community

50 yrs

(year, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL)

(d) Street No.

(If rural give precinct)

(e) If foreign born, how long in U. S. A.?

years

3(a) FULL NAME

3(b) If veteran,

3(c) Social Security

Name war

No.

4. Sex

7

5. Color or race

W

6(a) Single, widowed, married, divorced

Widowed

6(b) Name of husband or wife

Daniel Rainwater

6(c) Age of husband or wife if alive

Years

7. Birth date of deceased

March 10 1875

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

Mo.

10. Usual occupation

Housekeeper

11. Industry or business

Own home

FATHER

12. Name

Levi Gosser

13. Birthplace

Russell Co Ky

MOTHER

14. Maiden name

Taylor

15. Birthplace

Mintonsville Ky

16(a) Informant's own signature

Dr. J. W. Wink

(b) Address

441 Sunny Side Ave, Ind.

17. BURIAL, CREMATION, OR REMOVAL

Place Mintonsville Bur Date 10-31-1945

18(a) Signature of funeral director

Lorne Dyer

(b) Address

Mintonsville Ky

19(a)

11-13-45

(b)

Dr. J. W. Wink

(Date received by local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 30-

1945

21. I hereby certify that I attended the deceased from May 1 1945 to Oct 30 1945 that I last saw him alive on Oct 2 1945 and that death occurred on the date stated above at 1:40 P. M.

Immediate cause of death

Chronic nephritis 2 yrs.

Due to

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature

C. B. Creech M.D.

(M. D. or other)

Address

Mintonsville Ky

Date signed 10-30-45

#2019