

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY WITH UNFADING 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. S. 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. 23974
 Registrar's No. 189

Registration District No. 320 Primary Registration District No. 2105

1. PLACE OF DEATH:
 (a) County Carter
 (b) City or town Oliver Hill, Ky.
 (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 _____ (years, months, or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County Carter
 (c) City or town Oliver Hill
 (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? _____ year

3(a) FULL NAME Jess E. Lyons
 3(b) If veteran, _____
 Name war _____
 3(c) Social Security No. 303-05-8780

4. Sex M 5. Color or race W. 6(a) Single, widowed, married, divorced _____

6(b) Name of husband or wife Eba Lyons
 6(c) Age of husband or wife if alive 64 Years

7. Birth date of deceased Feb. 7 1876
 (Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days 8 If less than one day _____ min.

9. Birthplace Ky.
 10. Usual occupation Brick Labourer
 11. Industry or business 3

FATHER
 12. Name James Lyons
 13. Birthplace Ky.

MOTHER
 14. Maiden name Sarah Mank
 15. Birthplace Ky.

16(a) Informant's own signature Clarence Lyons
 (b) Address Oliver Hill Ky.

17. BURIAL, CREMATION, OR REMOVAL
 Place Gr. Hill Cemetery Date Nov. 12 1944

18(a) Signature of Medical Director Philip A. Shusterman
 (b) Address Oliver Hill Ky.

19(a) Nov. 13 1944 (Date received by local registrar) (b) Clarence Lyons (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH Nov. 9 1944
 21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him alive on _____ and that death occurred on the date stated above at _____ M.
 Immediate cause of death _____ DURATION _____
 Due to Tuberculosis of lungs
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings:
 Of operations 13B
 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? _____ (c) Manner of injury _____

23. Signature W. H. Wheeler M.D. (M. D. or other) _____
 Address Oliver Hill, Ky. Date signed 11-16-44