

Ashcraft, Louisa Ashcraft 1864 - 1955



Form V. R. 1-A
 FEDERAL SECURITY AGENCY
 U. S. PUBLIC HEALTH SERVICE
 NATIONAL OFFICE VITAL STATISTICS

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

FILE NO. 116 55-20711
 REGISTRATION NO. 1154
 Registration District No. 755 Primary Registration District No. 6101

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE KY b. COUNTY Jefferson	
b. CITY (If outside corporate limits, write RURAL and give township) Anderson, Pa		c. CITY (If outside corporate limits, write RURAL and give township) Anderson, Pa	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) R. 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) LOUISE b. (Middle) ASHCRAFT c. (Last) ASHCRAFT		4. DATE OF DEATH (Month) (Day) (Year) Oct 21, 1955	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 15, 1864
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 91
13. FATHER'S NAME James Ashcraft		14. MOTHER'S MAIDEN NAME Nancy Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Anna Ashcraft
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO (b)	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201-081-16	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, other place)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	
22. I hereby certify that I attended the deceased from _____, 19____, and that death occurred at _____, 19____, from the cause and on the date stated above.			
23a. DATE SIGNED 10/26/55	23b. ADDRESS Fiscal Court Bldg	23c. SIGNATURE (Local or State)	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
25a. DATE REC'D BY LOCAL OFFICE 10/25/55	25b. REGISTRAR'S SIGNATURE	25c. FUNERAL DIRECTOR	25d. ADDRESS