

Rose, Lillie Fitzpatrick 1870 - 1944

Rose

23777

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. 184

Registration District No. 90 Primary Registration District No. 4201

1. PLACE OF DEATH:
(a) County Bourben
(b) City or town Rural
(c) Name of hospital or institution Jacksonville
(d) Length of stay: In hospital or community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County Bourben
(c) City or town Rural
(d) Street No. Jacksonville
(e) If foreign born, how long in U. S. A. _____ years

3(a) FULL NAME Mrs. Lillie Fitzpatrick Rose
3(b) If veteran, _____ No. _____
3(c) Social Security _____

4. Sex F 5. Color or race W 6. Single, widowed, married, divorced Married

7. Birth date of deceased Apr. 2 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Clark Co. Ky.
10. Usual occupation Home
11. Industry or business _____

FATHER { 12. Name James Fitzpatrick
13. Birthplace Ky.

MOTHER { 14. Maiden name Talitha Harlow
15. Birthplace Clark Co. Ky.

16(a) Informant's own signature William Rose,
(b) Address RFD, Paris, Ky.

17. BURIAL, CREMATION, OR REMOVAL
Place Paris, Ky. Date Nov. 11, 1944

18(a) Signature of funeral director Davis Funeral Home
(b) Address Paris, Ky.

19(a) Nov. 10-44 (Date received by local registrar) (b) Lavelle O. Orr (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9- 1944

21. I hereby certify that I attended the deceased from Oct 31 1944 to Nov 9 1944, that I last saw him alive on Oct 31 1944, and that death occurred on the date stated above at 9-30A M.

Immediate cause of death Coronary Occlusion
Due to Advanced Arteriosclerosis

DURATION

Other conditions (include pregnancy within 3 months of death) _____

Major findings: 94A-97
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 Wm. H. D. Taylor M.D.
(M. D. or other) _____
Address Paris, Ky. Date signed Nov 15, 1944

L. C. Orr