Form V. S. 1-A

COMMONWEALTH OF KENTUCKY
State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 26939
Registered No.

1. PLACE OF DEATH
County Grant
Vot. Pct. W Williamstown
Inc. Town Yes
City Williamstown Ky
Registration District No. 5263
Primary Registration District No. 5263
(No. ____ St. ____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Anna Agee Hicks
(a) Residence. No. North Main St (Usual place of abode) St. ____ Ward ____ (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hicks
6. DATE OF BIRTH Sept 28 1858
7. AGE Years 77 Months 1 Days 18 If LESS than 1 day ____ hrs. or ____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, sawmill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE Grant Co Ky

FATHER
13. NAME W. H. Agee
14. BIRTHPLACE Ky

MOTHER
15. MAIDEN NAME Bettie Carter
16. BIRTHPLACE Ky

17. INFORMANT J. W. Agee
(Address) Owenton Ky

18. BURIAL, CREMATION, OR REMOVAL
Place Holbrook Ky Date 11/ 17 1935

19. UNDERTAKER Coates Stewart & Hedger
(Address) Williamstown Ky

20. FILED Nov. 17, 1935 Mary B. Ellis Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov. 15, 1935

22. I HEREBY CERTIFY, That I attended deceased from 5-8- 1935 to 11-15- 1935
I last saw her alive on 11-15- 1935, death is said to have occurred on the date stated above, at 5 p. m.
The principal cause of death and related causes of importance in order of onset were as follows:

	Date of onset
Pneumonia - Pneumonia	11-13-35
Chronic Urinary Tract Disease	

Contributory cause of importance not related to principal cause:
Angina Pectoris

Name of operation None Date of ____
What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ____ date of injury ____ 19__
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury None
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify
(Signed) Bruce E. Kinney M. D.
(Address) Williamstown Ky

N. B. WRITE PLAINLY, WITH INDELIBLE INK—This is a PERMANENT RECORD. Every item of information should be given if possible. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING