

Form T. S. 1-A  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 COMMONWEALTH OF KENTUCKY  
 CERTIFICATE OF DEATH

State File No. **13618**  
 Registration No. **2687**  
 13698

Registration District No. **755** Primary Registration District No. **2275**

**1. PLACE OF DEATH:**  
 (a) County Jefferson Co.  
 (b) City or town Courtsville Ky  
 (c) Name of hospital or institution Little Sisters of the Poor  
 (d) Length of stay: In hospital or community 10 (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Kentucky (b) County Jefferson  
 (c) City or town Louisville, Ky.  
 (d) Street No. 622 South St  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_

**3(a) FULL NAME** Irene Greenwell  
 3(b) If veteran, Name was \_\_\_\_\_ 3(c) Social Security No. \_\_\_\_\_  
 4. Sex Female 5. Color of race White 6(a) Single, widowed, married, divorced single  
 7. Birth date of deceased: March 1st 1861 (Month) (Day) (Year)  
 8. AGE: 71 Years \_\_\_\_\_ Months \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
 9. Birthplace Louisville Ky  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_

**MOTHER**  
 12. Name Josua Greenwell  
 13. Birthplace Courtsville Ky  
 14. Maiden name Elizabeth Boone  
 15. Birthplace Louisville Ky

**FATHER**  
 16(a) Informant's own signature W. M. Moore  
 (b) Address 622 South St. Louisville

**17. BURIAL, CREMATION, OR REMOVAL**  
 Place St. Thomas Cem Date May 2, 1942  
 18(a) Signature of funeral director Mich Greenwell  
 (b) Address New Haven, Ky  
 19(a) 16 (Date received by local registrar) (b) \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH April 30 at 11:25 PM 1942  
 21. I hereby certify that I attended the deceased from April 1, 1942 to April 30, 1942, that I last saw him alive on April 29, 1942, and that death occurred on the date stated above at 10 P M.  
 Immediate cause of death Gen. arteriosclerosis  
Cerebral apoplexy  
 Due to \_\_\_\_\_  
 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 or in public place? \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature J. P. Forsee, M.D. (M. D. or other)  
 Address 501 F. M. Co. Bldg Date signed 5/1/42

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully checked for accuracy. 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.