

2878

Registration District No. 100 X Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Jefferson  
(b) City or town Louisville  
(c) Name of hospital or institution Little Sisters of the Poor  
(d) Length of stay: In hospital or community 14. 4 - 8  
(If not in hospital or institution write street number or location)  
(If outside city or town limits, write RURAL)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kentucky (b) County Jefferson  
(c) City or town Louisville  
(d) Street No. 622 So 10th St  
(e) If foreign born, how long in U. S. A. 30  
(If rural give precinct)

3(a) FULL NAME William Peake  
3(b) If veteran, Name war \_\_\_\_\_ 3(d) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6(a) Single, widowed, married, divorced Widowed

6(b) Name of husband or wife Amanda Colson  
6(c) Age of husband or wife if alive \_\_\_\_\_ Years

7. Birth date of deceased July - 22 - 1857  
(Month) (Day) (Year)

8. AGE: Years 88 Months 6 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Nelson Co Ky

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER { 12. Name William Peake

13. Birthplace \_\_\_\_\_

MOTHER { 14. Maiden name Lucinda Edelen

15. Birthplace \_\_\_\_\_

16(a) Informant's own signature Dr. Marie Emilie D...  
(b) Address 622 So 10th St Louisville Ky

17. BURIAL, CREMATION, OR REMOVAL  
Place Walmary Date Sept 12 1945

18(a) Signature of funeral director John W. Manning  
(b) Address Louisville, Ky

19(a) SEP 13 1945  
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10th 1945

21. I hereby certify that I attended the deceased from Sept 1st 1945 to Sept 10th 1945 that I last saw him alive on Sept 29th 1945 and that death occurred on the date stated above at 5 am

Immediate cause of death Chc myocarditis  
6 equaly arteriosclerosis  
Due to \_\_\_\_\_

DURATION Many

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operation 935

Of autopsy \_\_\_\_\_

22. If death was due to external cause, 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 plant, in public place? \_\_\_\_\_  
(Specify type of place)

While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature J.P. Forsee, M.D.  
(M. D. or other)

Address 501 Francis Bldg Date signed 9/12/45

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.