

NORTH CAROLINA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

242

1 PLACE OF DEATH *Nash* Registration District No. *6th File 0* State *NC* Register No. *168*
County *Nash* State *NC* Register No. *168*
Township *Rocky Mount* or Village *Park View Hospital* or *St.* Ward *2000*
City *Rocky Mount* No. *Park View Hospital* St. *2000* Ward *2000*
(If death occurred in a hospital or institution, give its NAME instead of street and number)
2 FULL NAME *Wiley Thomas May* 30965
(a) Residence, No. *30965* St. *2000* Ward *2000*
(Usual place of abode) (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 *M* 4 Color or Race *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*
6 Date of birth (month, day, and year) *Oct 13 1889*
7 Age years Months Days If LESS than 1 day, hrs. or min. *31*
8 Occupation of deceased (a) Trade, Profession, or particular kind of work *Insurance* (b) General nature of industry, business, or establishment in which employed (or employer) *Bookkeeping* (c) Name of employer *Nash Co*

9 Birthplace (city or town) *Nash Co* (State or country) *NC*

10 Name of Father *R L May*

11 Birthplace of Father (city or town) *Nash Co* (State or country) *NC*

12 Maiden Name of Mother *Margaret Drotter*

13 Birthplace of Mother (city or town) *Nash Co* (State or country) *NC*

14 Informant *R L May* (Address) *# 3 Rymont*

15 Filed *12/19/20* *H Lee Luge* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 Date of Death (month, day, and year) *Dec 18 1920*

17 I HEREBY CERTIFY, That I attended deceased from *4 miles* *18*, 19*20*, to *12:30* *Dec 18*, 19*20*, that I last saw him alive on *Dec 18*, 19*20*, and that death occurred, on the date stated above, at *10:20* a.m.

The CAUSE OF DEATH* was as follows: *Neurasthenia*
due to overwork
due to (duration) *3* yrs. *6* mos. *1* ds.

Contributory (SECONDARY) *195* (duration) *3* yrs. *6* mos. *1* ds.

18 Where was disease contracted? *at home* If not at place of death?

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis? (Signed) *C. V. Drotter* M.D.

19 Place of Burial, Cremation, or removal *Red Oak Township* Date of Burial *Dec 19 1920*

20 Undertaker *R R Day* Address *Rymont*

Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.