Department of Commerce
Bureau of the Census

# CERTIFICATE OF DEATH
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

State File No. 4307
Registered No.

2-21-40—60M.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Form V. S. 12

**1. PLACE OF DEATH**
(a) County Norfolk — Registration district No. 243 (For reg. use) 0649
(b) Magisterial district
(c) City or town Portsmouth, Va.
(d) Name of hospital or institution Nor Nav Hosp,
(e) Length of stay in hosp. or inst. 7 days in this community (Specify whether years, months, or days)
(f) Is place of death within corporate limits?

**2. USUAL RESIDENCE OF DECEASED** United States Navy
(a) State
(b) County
(c) City or town
(d) Street No.
(e) Is place of residence within corporate limits?
(f) If foreign birth, how long in U. S. A? 0640 Years

3. (a) FULL NAME KIERNAN, James Francis MM-2c U.S.N.
3. (b) If veteran, name war

4. Sex M | 5. Color or race W | 6. (a) Single, married, widowed, divorced. Single
6. (b) Name of husband or wife

7. Date of birth of deceased October 8, 1919 (Month by name) (Day) (Year)

8. Age: Years 22 | Months 4 | Days 1 | If less than one day ____ hours ____ min.

9. Birthplace New York (City, town, or county) (State or foreign country)
10. Usual occupation U.S.Navy
11. Industry or business

Father — 12. Name Unknown
13. Birthplace " (City, town, or county) (State or foreign country)

Mother — 14. Maiden name Unkonwn
15. Birthplace " (City, town or county) (State or foreign country)

16. (a) Informant's own signature Man's service record
(b) Address

17. (a) Burial, cremation, or removal? Removal
(b) Place New York City Date 2-12-42 (Month by name) (Day) (Year)
18. (a) Signature of funeral director Richardson and Foster
(b) Address Portsmouth, Va.

19. Filed FEB 11 1942 (Date received by Reg.) Local, deputy or subregistrar's signature

**MEDICAL CERTIFICATION**

20. Date of death February 9 (Month by name) (Day) 19 42 (Year) at 1807M (Hour)

21. I hereby certify that I attended the deceased from 2-9-42 19 ; to 2-9-42 19 ; that I last saw h im alive on 2-9-42 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage — Duration
Subarachnoid
Due to 083A
Due to
Other conditions (Include pregnancy within 3 months of death)

Name of operation
Date of operation Major findings: (a) of operations
(b) of autopsy Yes

Physician — Underline the primary cause to which death should be charged statistically.

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A.S.Lloyd Lt-Comdr MC M. D., Cor., or other
Address Nor Nav Hosp, Pts, Va. Date signed 2-10-42