

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. **23845**

Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

City **Muklenburg**Village **Spencer**

Inc. Town _____

City _____

Registration District No. **1095**Primary Registration District No. **19**

No. _____ St. _____ Ward _____

2 FULL NAME **Olias A. Adcock**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **White** 5 Single ☐ Married ☒ Widowed ☐ or Divorced ☐ (Write period)6 DATE OF BIRTH **Oct 30 1863**
(Month) (Day) (Year)7 AGE **63** yrs. **11** mos. **11** ds. IF LESS than 1 day _____ hrs. or _____ min?8 OCCUPATION
(a) Trade, profession or particular kind of work. **Farmer**
(b) General nature of industry, business or establishment in which employed (or employer) _____9 BIRTHPLACE (State or country) **Muklenburg Co**10 NAME OF FATHER **Olias Adcock**11 BIRTHPLACE OF FATHER (State or country) **Muklenburg Co**12 MAIDEN NAME OF MOTHER **Sallie Rose**13 BIRTHPLACE OF MOTHER (State or country) **Muklenburg Co**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Olias Adcock**
(Address) **Spencer 14**15 Filed **Sept 22**, 1926 **Dan Napier**

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **Sept 20 1926**
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from **Aug 11**, 1926, to **Sept 20**, 1926, that I last saw him alive on **Aug 9**, 1926, and that death occurred on the date stated above at **7 A. M.**The CAUSE OF DEATH* was as follows:
Pneumonia & Stomach(Duration) yrs. **3** mos. **11** ds.
Contributor **Chronic Interstitial**
(Secondary) **Phthisis**(Signed) **Ed Shalton** M. D.
Sept 20, 1926 (Address) **Central City Ky**

*State the Disease causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
at place of death yrs. **11** mos. **11** ds. In the State yrs. **11** mos. **11** ds.Where was disease contracted, if not at place of death?
Former or usual residence _____19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Rose Cemetery Charleston Sept 21 192620 UNDERTAKER **J. H. Lashier** ADDRESS **Spencer 14**

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Get statement of OCCUPATION in every important. See instructions on back of certificate.