

STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHFile No. **11735**Registered No. **30**

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

1 PLACE OF DEATH
County Meigs

Vol. Pct. _____ Registration District No. 1087

Inc. Town Central City Primary Registration District No. 2435

City _____ (No. _____ St. _____ Ward _____)

2 FULL NAME Georgia May Almon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single single
Married _____
Widowed _____
Or Divorced _____
(Write the word)

6 DATE OF BIRTH Feb. 23 1907
(Month) (Day) (Year)

7 AGE 20 yrs. 1 mo. 25 ds.
if less than 1 day _____ hrs. or _____ min?

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Ky.

PARENTS

10 NAME OF FATHER Kemp Almon

11 BIRTHPLACE OF FATHER (State or country) Ky.

12 MAIDEN NAME OF MOTHER Betha Jackson

13 BIRTHPLACE OF MOTHER (State or country) Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kemp Almon
(Address) Central City Ky.

15 Filed May 15th 1927 A. L. Shaeffer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 17 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from Sept 17 1927 to April 17 1927, and that I last saw her on April 17 1927, and that death occurred on the date stated above at 9:30 a.m.

The CAUSE OF DEATH* was as follows:
Epilepsy

(Duration) 18 yrs. 8 mos. _____ ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. McSperry M. D.
Apr. 17, 1927 (Address) Central City Ky.

*State the disease causing death, or in death from Violent Cause 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 _____ In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____

if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Fairmount DATE OF BURIAL April 18 1927

20 UNDERTAKER Arthur T. Mosley ADDRESS Central City Ky.

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain, so that it may be properly classified. Do not state statement of OCCUPATION in every important. See instructions on back of certificate.