

Commonwealth of Kentucky  
STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County *Mullins*

Vol. No. *# 4*

Inc. Town

City

Registration District No. *870*

Primary Registration District No. *2435*

(No. St., Ward)

File No. *24003*

Registered No. *59*

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

FULL NAME *William B. Atherton*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*  
(Write the word)

6 DATE OF BIRTH *April 20, 1880*  
(Month) (Day) (Year)

7 AGE *34 yrs. 5 mos. 5 ds.* IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) *Ohio Co*

10 NAME OF FATHER *John J. Ferguson*

11 BIRTHPLACE OF FATHER (State or country) *Ohio Co*

12 MAIDEN NAME OF MOTHER *Susan Gault*

13 BIRTHPLACE OF MOTHER (State or country) *Ohio Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *J. B. Atherton*  
(Address) *Central City, Ky.*

15 Filed *Oct. 6, 1916* *A. L. Blandford*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 21, 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 20, 1916* to *Sept 21, 1916*, that I last saw him alive on *Sept 20, 1916*, and that death occurred on the date stated above at *9 a.m.* The CAUSE OF DEATH\* was as follows:  
*Heart failure, mixed*

(Duration) ... yrs. ... mos. ... ds.  
Contributory (SECONDARY) *Intestines*  
(Duration) ... yrs. ... mos. ... ds.

(Signed) *F. K. Foley* M. D.  
*Sept. 22, 1916* (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. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.  
Where was disease contracted, if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Clarks* DATE OF BURIAL *Sept 21, 1916*

20 UNDERTAKER *Mustin Moon* ADDRESS *Central City*

MARCH RESERVED FOR RECORDS

B. B.—Every item of information should be carefully supplied. All 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.