

COMMONWEALTH OF KENTUCKY
 State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 6969
 Registered No. 24

1 PLACE OF DEATH
 County Spencer
 Inc. Town Central City
 City _____ (No. _____) St. _____ Ward _____

Vot. Pct. _____ Registration District No. 1087
 Primary Registration District No. 2435

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

2 FULL NAME Sarah Jane Baber

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Widowed
 Married or Divorced (Write the word)
 6 DATE OF BIRTH February 25 1852
 (Month) (Day) (Year)
 7 AGE 75 yrs. 19 mos. 19 ds. IF LESS than 1 day _____ hrs. or _____ min?
 8 OCCUPATION (a) Trade, profession or particular kind of work. None
 (b) General nature of industry, business or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Kentucky
 10 NAME OF FATHER J. John Ward
 11 BIRTHPLACE OF FATHER (State or country) Kentucky
 12 MAIDEN NAME OF MOTHER Veliah Ward
 13 BIRTHPLACE OF MOTHER (State or country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. W. Baber
 (Address) Central City

15 Filed 4/1 1927 L. L. Shauford Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 16th, 1927
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from 3-1- 1927 to 3-16 1927 that I last saw her alive on 3-8- 1927 and that death occurred on the date stated above at 9:50 p.m.

The CAUSE OF DEATH was as follows:
Pneumonia
 (Duration) _____ yrs. _____ mos. 16 ds.

Contributory (Secondary) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. H. Riley M.D.
3-16 1927 (Address) Central City

*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 _____ 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 DATE OF BURIAL
Cherry Hill Cemetery 3/17/ 1927
 20 UNDERTAKER ADDRESS
E. J. Anderson Central City

WRITE PLAINLY, IN UNFADING 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 terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.