

## A TRACE OF DEATH

COMMONWEALTH OF KENTUCKY  
State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHFile No. **27415**County MuhlenbergVet. Pat. PowderlyRegistration District No. 1093

Registered No. \_\_\_\_\_

Ine. Town \_\_\_\_\_

Primary Registration District No. 6829

City \_\_\_\_\_

(No. \_\_\_\_\_ St., \_\_\_\_\_ Ward)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME Mary Ball

(a) Residence. No. \_\_\_\_\_ St., \_\_\_\_\_ Ward. \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married Widowed Widow or Divorced (Write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH July 9, 1857  
(Month) (Day) (Year)7 AGE 72 yrs. 3 mos. 0 ds. IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) MuhlenbergPARENTS  
10 NAME OF FATHER William Vaught  
11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (city or town) Unknown  
(State or country)14 (Informant) Calvin Monroe Steel  
(Address) Powderly, Kentucky15 Filed 10/10/29 C. B. Wickliffe  
By M. Walls Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 9, 1929  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1929, to Oct 9, 1929 that I last saw hbx. alive on Oct 9, 1929 and that death occurred on the date stated above at 6.10 m. The CAUSE OF DEATH<sup>1</sup> was as follows:  
Lymphosarcoma(Duration) \_\_\_\_\_ yrs. 6 mos. \_\_\_\_\_ ds.Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 18 WHERE WAS DISEASE CONTRACTED

If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) C. B. Wickliffe, M. D.Oct. 10, 1929 (Address) Greenville Ky

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Dovey Grave Yard DATE OF BURIAL Oct. 10, 192920 UNDERTAKER Orin L. Roark ADDRESS Greenville, Ky.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

M. D.--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. Exact statement of OCCUPATION is very important. See instructions on back of certificate.