25663

FORM V S 1-500M 2-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No. .....

Registered No. .....

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

1 PLACE OF DEATH
County Muhlenberg
Vot. Pct. ..... Registration District No. 67
Ino. Town ..... Primary Registration District No. 2136
City Greenville Ky No. ..... St., ... Ward)

2 FULL NAME Margaret Elizabeth Bandy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: W
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed
6 DATE OF BIRTH: October 9, 1920 (Month) (Day) (Year)
7 AGE: 7 9 yrs. ..... mos. ..... 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): Daviess Co Ky

PARENTS
10 NAME OF FATHER: John W. Harrison
11 BIRTHPLACE OF FATHER (State or country): Kentucky
12 MAIDEN NAME OF MOTHER: Dont know
13 BIRTHPLACE OF MOTHER (State or country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt. Bandy
(Address) Greenville Ky

15 Filed 10/10 20 C B Wickliffe Registrar
11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 9, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to Oct 9, 1930, that I last saw h[illegible] alive on Oct 9, 1930, and that death occurred on the date stated above at 12 Noon. The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) L. P. Moore, M. D.
(Address) Greenville 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: Friendship
DATE OF BURIAL: 10/10 1930

20 UNDERTAKER: [illegible]
ADDRESS: Greenville Ky

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH 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.