

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

1 PLACE OF DEATH

County *Muhlenberg*Vol. No. *10*Registration District No. *1*

Inc. Town

Primary Registration District No. *471*

City

(No. *13* St., *213* Ward)

2 FULL NAME

*Eula Bivins*File No. *24921*

Registered No.

(If death occurred in a hospital or institution, give the name, location of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *single*  
(Write the word)6 DATE OF BIRTH ..... 1 .....  
(Month) (Day) (Year)

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

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. *at home*  
(b) General nature of industry, business or establishment in which employed (or employer)9 BIRTHPLACE (State or country) *Muhlenberg Co. Ky*10 NAME OF FATHER *Thos Bivins*11 BIRTHPLACE OF FATHER (State or country) *Muhlenberg Co. Ky*12 MAIDEN NAME OF MOTHER *Delia Wells*13 BIRTHPLACE OF MOTHER (State or country) *not known*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Willie Boggs*(Address) *Greensville Ky*15 Filed *9/4*, 191*6* by *C.B. Nickliffe* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 1, 1916*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Aug 16, 1916*, to *Sept 1, 1916*, that I last saw her alive on *Aug 30, 1916*, and that death occurred on the date stated above at *13 St., 213*. The CAUSE OF DEATH\* was as follows:*Typhoid fever*  
(Duration) ..... yrs. .... mos. .... ds.Contributory (SECONDARY) .....  
(Duration) ..... yrs. .... mos. .... ds.(Signed) *A. B. Latham, M. D.*  
*Sept 1, 1916* (Address) *Greensville*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES show (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. State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL *Green Brier Bldg.* DATE OF BURIAL *Sept 2, 1916*20 UNDERTAKER *McDonald & Dewitt* ADDRESS *Greensville Ky*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
MARCH RESERVE FOR INDEXING  
B. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Short statement of OCCUPATION is very important. See instructions on back of certificate.