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

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

16666

File No. .....
Registered No. 11
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County Muhlenberg
Vet. Pct. ..... Registration District No. .....
Inc. Town Nelson Primary Registration District No. .....
City ..... (No. ..... St., ... Ward)

2 FULL NAME James Samuel Bourne

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	White	Single

6 DATE OF BIRTH: March (Month) 16 (Day), 1897 (Year)

7 AGE: 22 yrs. 1 mos. 22 ds. — IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Muhlenberg

PARENTS

10 NAME OF FATHER: James Bourne
11 BIRTHPLACE OF FATHER (State or country): Grayson Co Ky
12 MAIDEN NAME OF MOTHER: Mary Emilie McDa[illegible]
13 BIRTHPLACE OF MOTHER (State or country): Ohio Co Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary E. Spencer
(Address) Nelson Ky

15 Filed 5/18", 1919 S.O. Maple REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) D (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan., 1919, to May 7., 1919, that I last saw h[illegible] alive on May 7th., 1919, and that death occurred on the date stated above at ... m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. 1 mos. ... ds.

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

(Signed) O. T. Masenen[illegible], M. D.
May 18, 1919 (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: Rose Grayson — DATE OF BURIAL: May 7., 1919

20 UNDERTAKER: Martin Moon — ADDRESS: Central City

cc 1365 10/28/24 cc 89 1/6/25