

1 PLACE OF DEATH

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2441

County Muhlenberg

File No. _____

Vet. Pat. West BogressRegistration District No. 1693

Registered No. _____

Ine. Town _____

Primary Registration District No. 4533

City _____

(No. _____ St., _____ Ward)

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

2 FULL NAME James Albert Brewer

(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 Male 4 COLOR OR RACE White 5 Single Married
Widowed Widower
or Divorced
(Write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6 DATE OF BIRTH December 7, 1848
(Month) (Day) (Year)7 AGE 82 yrs. 28 mos. 28 ds. IF LESS than 1
day _____ hrs. or _____ min?8 OCCUPATION OF DECEASED
(a) Trade, profession or Farmer
particular kind of work
(b) General nature of industry,
business or establishment in
which employed (or employer) _____9 BIRTHPLACE (city or town)
(State or country) Wilson County, Tenn.PARENTS
10 NAME OF FATHER James Wesley Brewer
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Tennessee
12 MAIDEN NAME OF MOTHER -- -- Lanham
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Tennessee14 (Informant) F. E. Brewer
(Address) Depoy, Kentucky15 Filed 1/5, 1931 G. H. ...
By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1/5, 1931
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased
from On Dec. 26, 1930, to _____, 19____,
that I last saw h..... alive on _____, 19____,and that death occurred on the date stated above at 5 A. m.
The CAUSE OF DEATH* was as follows: 108
Lobar Pneumonia, following an attack
of Influenza.(Duration) _____ yrs. _____ mos. 15 ds.
Contributory Old Age.
(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) E. G. Argabrite
1/5, 1931 (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 Vernal Grove DATE OF BURIAL 1/6, 1931, 19____20 UNDERTAKER Oren L. Roark ADDRESS Greenville, Ky.

CORD

UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITHOUT

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.