

**COMMONWEALTH OF KENTUCKY**  
State Board of Health  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

File No. 13553  
Registered No. 14

**1 PLACE OF DEATH**County MecklenburgVot. Pct. Midway 6815

Inc. Town.....

City.....

Registration District No. 1086Primary Registration District No. 2869

(No. .... St. .... Ward)

**2 FULL NAME**Edua Edogabeta Brooks

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

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <u>Female</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 Single Married Widowed or Divorced (Write the word)</b> <u>Single</u>
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<b>6 DATE OF BIRTH</b> <u>May 7th</u> (Month) (Day) (Year)
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<b>7 AGE</b> <u>Still Born</u> ..... yrs. .... mos. .... ds.	<b>IF LESS than 1 day</b> ..... hrs. .... min?
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**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) Sy.

**10 NAME OF FATHER**  
Estill Brothers

**11 BIRTHPLACE OF FATHER**  
(State or country) Sy.

**12 MAIDEN NAME OF MOTHER**  
Hazel Bruce

**13 BIRTHPLACE OF MOTHER**  
(State or country) Sy.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Walter Vincent  
(Address) Central City Ky.

**15**  
Filed May 10, 1928 Dollie Robertson  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
5-7-1928  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased**  
from ..... 192....., to ..... 192.....,

that I last saw h..... alive on ..... 192.....  
and that death occurred on the date stated above at ..... m.

**The CAUSE OF DEATH\* was as follows:**  
Still born.

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

**Contributory**  
(Secondary) (Duration) ..... yrs. .... mos. .... ds.

(Signed) St. Urmitz, M. D.  
5-7-1928 (Address) Bremser 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 ..... yrs. .... mos. .... ds. In the  
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** **DATE OF BURIAL**  
Mt Pisgah May 4th 1928

**20 UNDERTAKER** **ADDRESS**  
J. B. Brooks Bremser Ky.

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.

MAILED RECEIVED FOR RECORDS