

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

1 PLACE OF DEATH
County Muhlenberg

Vet. Post _____

Inc. Town Central City

City _____ (No. _____ St.) _____ Ward _____

Registration District No. 870

Primary Registration Dist. No. 2435

File No. 2554

Registered No. 4

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

3 FULL NAME May Brown

PERSONAL AND STATISTICAL PARTICULARS

4 SEX female 5 COLOR OR RACE white 6 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____

7 DATE OF BIRTH October 31, 1913
(Month) (Day) (Year)

8 AGE _____ yrs. 2 mos. 3 ds. If LESS than 1 day _____ hrs. or _____ min.?

9 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) _____

10 BIRTHPLACE (State or country) Central City Ky.

PARENTS

11 NAME OF FATHER Estle B. Brown

12 BIRTHPLACE OF FATHER (State or country) Buttler Co.

13 MAIDEN NAME OF MOTHER Etta Stroud

14 BIRTHPLACE OF MOTHER (State or country) Central City Ky.

15 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Fred Haliday (Address) _____

16 Filed Feb 4, 1914 D. L. Blandford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Illness, 1913, to _____, 1913, that I last saw h_____ alive on _____, 1913, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: Mal formation of heart
(Duration) _____ yrs. 2 mos. _____ ds.

Contributory none (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. McQuinn M. D. Central City Ky. 1914 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOL_____ CAUSE, 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 Warrmount Cemetery DATE OF BURIAL Jan 4, 1914

20 UNDERTAKER None ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language so that it may be properly classified. Extent of OCCUPATION is very important. See instructions on back of certificate.