

23078

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

File No. _____
Registered No. 17

1 PLACE OF DEATH
County Muhlenberg
Vot. Prec. Graham
Inc. Town _____
City _____

Registration District No. 1096
Primary Registration District No. 6847

(No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME in _____ number)

2 FULL NAME Wallace Ray Brown

(a) Residence. No. Graham 14 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.

DELETED

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Married Widowed Divorced
(Write the word)
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
6 DATE OF BIRTH March 12 1934
(Month) (Day) (Year)
7 AGE 1 yrs. 5 mos. 11 ds. IF LESS than 1 day _____ hrs. or _____ min?

8 OCCUPATION OF DECEASED
(a) Trade, profession or 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) Muhlenberg Mo Ky

PARENTS
10 NAME OF FATHER Melvin Brown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Muhlenberg Mo Ky
12 MAIDEN NAME OF MOTHER Ester Majon
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Muhlenberg Mo Ky

14 (Informant) Melvin Brown
(Address) Graham Ky

15 Aug 23, 1935 Hubert Craft
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 23, 1935
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1934, to Aug 23, 1935, that I last saw him alive on Aug 10, 1935, and that death occurred on the date stated above at 19 mo. The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory Malnutrition and Hypertension
(Secondary) (Duration) _____ yrs. _____ mos. _____ ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death? _____
Did an operation precede death? no. Date of _____
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) M. E. Lofter, M. D.
8-23, 1935 (Address) Graham, 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 Youngs Chapel DATE OF BURIAL Aug 24, 1935
20 UNDERTAKER M. B. McDonald and Co. ADDRESS Burnsville Ky

MADE RESERVED FOR INDEXING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be 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.