

## COMMONWEALTH OF KENTUCKY

State Board of Health

BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

16721

1. PLACE OF DEATH  
County MuhlenbergVot. Pot. \_\_\_\_\_ Registration District No. 1095Inc. Town Greenville Primary Registration District No. 2434City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME Cynthia Ann Browning(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 Female 4 COLOR OR RACE white 5 Single Widowed  
Married  
Widowed  
or Divorced  
(Write the word)5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH \_\_\_\_\_  
(Month) (Day) (Year)7 AGE 80 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1  
day \_\_\_\_\_ hrs. \_\_\_\_\_  
or \_\_\_\_\_ min?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or  
particular kind of work None  
(b) General nature of industry,  
business or establishment in  
which employed (or employer) \_\_\_\_\_9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) ky10 NAME OF FATHER Henry R. Hooper11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) ky12 MAIDEN NAME OF MOTHER Elizabeth Weston13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) ky14 (Informant) Mr. M. Reynolds  
(Address) Greenville - ky15 Filed 7-5-27 C. B. Dickie  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4, 1927  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased  
from May 1, 1927, July 4, 1927  
that I last saw her alive on July 3, 1927  
and that death occurred on the date stated above at 10 P.M.  
The CAUSE OF DEATH\* was as follows  
Pneumonia Hypostatic(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.  
Contributory fractured hip (right)  
(Secondary)  
(Duration) \_\_\_\_\_ yrs. 2 mos. 4 ds.

## 18 WHERE WAS DISEASE CONTRACTED

If not at place of death? Did an operation precede death? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) Spencer M. D.

\_\_\_\_\_, 19\_\_\_\_ (Address)

\*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 addi-  
tional space.)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenville ky July 5, 1927

20 UNDERTAKER ADDRESS

M. B. McDonald Greenville ky

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.