FORM V. S. 1-100 M-1-10-11.

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

# CERTIFICATE OF DEATH

25947

1 PLACE OF DEATH 7122

County Muhlenberg

Vot. Pct. No 2

Inc. Town Bremen

Registration District No. 2 7122

Primary Registration Dist. No. 2

File No.

Registered No. 64

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

City ..... (No. ....., ..... St.; ..... Ward)

2 FULL NAME Palace L. Bruice

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: August (Month) 15th (Day), 1861 (Year)

7 AGE: 51 yrs. 1 mos. 21 ds. If LESS than 1 day ....hrs, or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): Self

9 BIRTHPLACE (State or country): Muhlenberg Co. Ky

PARENTS

10 NAME OF FATHER: William Bruice

11 BIRTHPLACE OF FATHER (State or country): Muhlenberg Co. Ky

12 MAIDEN NAME OF MOTHER: Mary Jane Johnson

13 BIRTHPLACE OF MOTHER (State or country): Butler Co. Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ruffus Bruice

(Address) Bremen Ky

15 Filed Oct 5, 1912 W. C. Grundy, Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 5th (Day), 1912 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1912, to October 5, 1912, that I last saw him alive on Oct. 5th, 1912, and that death occured, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage of Typhoid Fever

(Duration) ..... yrs. ..... mos. 11 ds.

Contributory (SECONDARY) .....

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

(Signed) Wm. T. Mersencup, M. D.

Oct. 5, 1912 (Address) Bremen 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 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: Charles Chapel

DATE OF BURIAL: Oct 5, 191..

20 UNDERTAKER: R. Stuart

ADDRESS: Bremen Ky

11—6186

WRITE PLAINLY, WITH [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated [illegible] 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.