FORM V S 1-500M. 2-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

17981

1 PLACE OF DEATH

County *Muhlenburg*

Vot. Pct. *20* Registration District No. *7140* File No. ....

Inc. Town .... Primary Registration District No. .... Registered No. *23*

City .... (No. .... St., ... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Jas A Chaney*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*

4 COLOR OR RACE *White*

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

6 DATE OF BIRTH *Don't Know* .... , 1 .... (Month) (Day) (Year)

7 AGE .... yrs. .... mos. .... ds. IF LESS than 1 day... hrs. or... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *Coal Miner*
(b) General nature of industry business or establishment in which employed (or employer) ....

9 BIRTHPLACE (State or country) *Logan County Ky*

PARENTS

10 NAME OF FATHER *Smith Chaney*

11 BIRTHPLACE OF FATHER (State or country) *Don't Know*

12 MAIDEN NAME OF MOTHER *Lucinda Hinton*

13 BIRTHPLACE OF MOTHER (State or country) *Logan County Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Smith Chaney*

(Address) *St Charles Ky*

15 Filed *June 12* 191*7* *J J Kennedy* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *6* *11* , *1917* (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *April 20*, 191*7*, to *June 11*, 191*7*, that I last saw h*im* alive on *June 2*, 191*7*, and that death occurred on the date stated above at *4.40 p*m. The CAUSE OF DEATH* was as follows:

Tuberculosis bowels

(Duration) *2* yrs. .... mos. .... ds.

Contributory (SECONDARY) ....

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

(Signed) *T R Finley*, M. D.

June 14, 191*7*. (Address) *St Charles 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 *Nohama*

DATE OF BURIAL *June 12*, 191*7*

20 UNDERTAKER *C L Croft*

ADDRESS *Nohama Ky*

11—3184

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.