FORM V S 1-500M.

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Mecklenburg

Vot. Pct. Carrollton Ky Registration District No. 7121

Inc. Town Worsaw Ky Primary Registration District No. ....

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

File No. 29650

Registered No. 1529

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

2 FULL NAME Mary Palestean Claves

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

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

6 DATE OF BIRTH .... , 1 ...... (Month) (Day) (Year)

7 AGE 64 yrs. ...... mos. ...... ds.

IF LESS than 1 day... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) Harden co

PARENTS

10 NAME OF FATHER John Sheehany

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

12 MAIDEN NAME OF MOTHER Debeh Deny

13 BIRTHPLACE OF MOTHER (State or country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Claves

(Address) Warsaw Ky

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Filed Oct 4, 1914 A. L. Hocker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 3rd, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1914, to Nov 3, 1914, that I last saw her alive on Nov 3, 1914, and that death occurred on the date stated above at 11:30 m. The CAUSE OF DEATH* was as follows:

Flux

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

Contributory (SECONDARY) Chronic Asthma for years (Duration) ...... yrs. ...... mos. ...... ds.

(Signed) J. R. Barnes, M. D.

Nov 4, 1914 (Address) So Carrollton 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 Wagn Hope

DATE OF BURIAL Oct. 4, 1914

20 UNDERTAKER W. E. Hacker

ADDRESS So Carrollton

11—3184

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MARGIN RESERVED FOR BINDING
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.