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

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

30842

1 PLACE OF DEATH

County Muhlenburg Vot. Pct. So. Carrollton Registration District No. 7124

Inc. Town ..... Primary Registration District No. .....

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

File No. 5

Registered No. 711

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

2 FULL NAME Unnamed Crossland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Girl

4 COLOR OR RACE: white

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

6 DATE OF BIRTH: Nov. 9, 1919 (Month) (Day) (Year)

7 AGE: Born dead yrs. mos. ds.

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

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

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

PARENTS

10 NAME OF FATHER: Burnis Crossland

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

12 MAIDEN NAME OF MOTHER: Lacie Chapman

13 BIRTHPLACE OF MOTHER (State or country): Mayfield, Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Burnis Crossland

(Address) So. Carrollton, Ky.

15 Filed Nov 4, 1919 A.G. Hocker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. 9 (Month) (Day), 1919 (Year)

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

Stat Known
Born Dead
Malformed (Hydrocephalus)
Craniotomy (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....
(Duration) ..... yrs. ..... mos. ..... ds.

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

Nov. 9, 1919 (Address) .....

*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: So. Carrollton Cemetery — DATE OF BURIAL: Nov. 10, 1919

20 UNDERTAKER: Burnis Crossland — ADDRESS: So. Carrollton Ky

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.

11—3184