

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Wright

Vet. Pot. 15

Inq. Town Chalmers

City Hubert Lee Drake

Registration District No. 7135

Primary Registration District No. \_\_\_\_\_

(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME Hubert Lee Drake

File No. 24029

Registered No. 33

(If death occurred in a hospital or institution give its name instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
(Write the word)

6 DATE OF BIRTH Sept 8<sup>th</sup> 1916  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 20 ds. IF LESS than 1 day... hrs. or... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none  
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ky

10 NAME OF FATHER M B Drake

11 BIRTHPLACE OF FATHER (State or country) Ky

12 MAIDEN NAME OF MOTHER Minnie Jones

13 BIRTHPLACE OF MOTHER (State or country) Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M B Drake

(Address) Greenville Ky

15 Filed 9-28-16 W.H. Moore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 28 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date stated above at 4 a.m. The CAUSE OF DEATH\* was as follows:

Heart failure

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) G.B. Youngs  
Sept 28, 1916 (Address) City, Ky

\*State the DISEASE CAUSING DEATH, or, in deaths from violent causes, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDE.

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 Wright Ky DATE OF BURIAL 9-29 1916

20 UNDERTAKER J. K. Thomas ADDRESS Chalmers Ky

MARGIN RESERVED FOR MEMORANDUM

WRITE PLAINLY. USE WEARING INK--THIS IS A PERMANENT RECORD. B. 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.