

Commonwealth of Kentucky  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

36080

## PLACE OF DEATH

County *Mitchell*Vet. Post *W. C. Hawks*

Inc. Town

Registration District No. *571*Primary Registration District No. *7151*

City

(No.)

St.

Ward

## FULL NAME

*Sarah A. Duggs*

File No. ....

Registered No. ....

 (If death occurred in a  
 hospital or institution,  
 give the street address of  
 street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

 SEX *Female* COLOR OR RACE *white* SINGLE, MARRIED, WIDOWED, OR DIVORCED *married*  
 (Write the word)

DATE OF BIRTH

, 1 (Month) (Day) (Year)

AGE

60 yrs. mos. da. IF LESS than 1 day... hrs. or... min.?

OCCUPATION

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

BIRTHPLACE

*Mitchell Co. Ky*
 10 NAME OF FATHER *John J. Duggs*

 11 BIRTHPLACE OF FATHER *Mitchell Co. Ky*

 12 MAIDEN NAME OF MOTHER *Don't know*

13 BIRTHPLACE OF MOTHER

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *M. A. Bivins*(Address) *Greenville Ky*
 15 Filed *Nov 16* 1918 *W. C. Hawks* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

~~Nov 15~~ *Nov 15* 1918  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from *Aug* 1917, to *Nov 3* 1917,

 that I last saw her alive on *Nov 3* 1917,

and that death occurred on the date stated above at ..... m.

THE CAUSE OF DEATH was as follows:

*irritation of heart**with lost compensation*
 (Duration) *1* yrs. *3* mos. *0* ds.

 Contributory *Malaria and Jaundice*

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

 (Signed) *J. E. Grace*, M. D.  
*Nov 15* 1918 (Address) *Greenville Ky*

\*State the DISEASE CAUSING DEATH, or, in deaths from VOLUNTARY 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. .... da. State ..... yrs. .... mos. .... da.

Where was disease contracted, if not at place of death?

Former or usual residence .....

 19 PLACE OF BURIAL OR REMOVAL *Johnston Bldg. Nov 16, 1918*

 20 UNDERTAKER *M. Donald & Son* *Greenville*

DATE OF BURIAL

ADDRESS

U. S. - Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly CAPTIONED. INSTRUCTIONS ON BACK OF CERTIFICATE IS VERY IMPORTANT.

WRITE PLAINLY, WITH SPACING INC. THIS IS A PARAGRAPH

*M. Duggs**24*