

Commonwealth of Kentucky

STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County

*Muhlenberg*

CERTIFICATE OF DEATH

Vot. Pat.

*E. Baggett*

Registration District No. *871*

File No. **18172**

Inc. Town

Primary Registration Dist. No. *7132*

Registered No. *65*

City

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

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

FULL NAME

*Jose H. Dussall*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>married</i>
6 DATE OF BIRTH <i>April 18 1844</i> (Month) (Day) (Year)		
7 AGE <i>68</i> yrs. <i>3</i> mos. _____ ds.		If LESS than 1 day _____ hrs. or _____ min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>Farmer</i> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <i>Ky.</i>		

PARENTS	10 NAME OF FATHER <i>David Dussall</i>
	11 BIRTHPLACE OF FATHER (State or country) <i>Ky.</i>
	12 MAIDEN NAME OF MOTHER <i>Harriet Boyfield</i>
	13 BIRTHPLACE OF MOTHER (State or country) <i>Ky.</i>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *John E. Jones*  
(Address) *Greenville P.M. 1 Ky*

15 Filed *July 20, 1912* *W. H. Franklin*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*7 29 1912*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May*, 1910, to *7/29/*, 1912, that I last saw him alive on *7/22/*, 1912, and that death occurred, on the date stated above, at *325*.

The CAUSE OF DEATH\* was as follows:  
*Hypertrophied Heart*

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

(Signed) *J. G. Edge*, M. D.  
*7/29/*, 1912 (Address) *Greenville, 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  
*Witchel Church*

DATE OF BURIAL  
*July 20 1912*

UNDERTAKER  
*Chas L Roark*

ADDRESS  
*Greenville*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

M. D.—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.