

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *Muhlenberg*

Vol. No. *West Central* Registration District No. *871*

Inc. Town ..... Primary Registration District No. *2436*

City *Greenville* (No. *Main-Cross* St., ..... Ward)

2 FULL NAME *David James Fleming*

File No. *23289*

Registered No. *80*

[If death occurred in a hospital or institution, give its NAME (street or street and number.)

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *January 10, 1834*  
(Month) (Day) (Year)

7 AGE *78* yrs. *7* mos. *26* ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) *Muhlenberg Co. Ky.*

10 NAME OF FATHER *Samuel Fleming*

11 BIRTHPLACE OF FATHER (State or country) *Pennsylvania*

12 MAIDEN NAME OF MOTHER *Amy Kinmond*

13 BIRTHPLACE OF MOTHER (State or country) *Kentucky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Mrs. R. F. Green*  
(Address) *Drakesboro, Ky.*

15 Filed *9/6*, 1912 SEP 6 - 1912  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 4*, 1912.  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 4*, 1912, to *Sept 4*, 1912, that I last saw him alive on *Sept 4*, 1912, and that death occurred on the date stated above at *8 P.M.* The CAUSE OF DEATH\* was as follows:

*Thrombia Fura*  
..... (Duration) ..... yrs. .... mos. .... ds.

Contributory *Leadian Drops*  
(SECONDARY) ..... (Duration) *8* yrs. .... mos. .... ds.

(Signed) *Harvey W. Deaton*, M. D.  
*Sept 5*, 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. State ..... yrs. .... mos. .... ds.

Where was disease contracted, If not at place of death? ..... Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL *Ends Graves* DATE OF BURIAL *9/6*, 1912

20 UNDERTAKER *Orie L. Rank* ADDRESS *Greenville, Ky.*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. 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. Short statement of OCCUPATION is very important. See instructions on back of certificate.