

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

34363

PLACE OF DEATH
County *Muhlenberg*

Vot. Pot. *North P. Office*

Registration District No. *871*

Ino. Town Primary Registration District No. *7132*

City (No. St., Ward)

2 FULL NAME *James Healey Fulkerson*

File No.

Registered No.

[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 *red white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *single*
(Write the word)

6 DATE OF BIRTH *Dec 4 1917*
(Month) (Day) (Year)

7 AGE yrs. mos. 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) *Muhlenberg co*

10 NAME OF FATHER *Willie Fulkerson*

11 BIRTHPLACE OF FATHER (State or country) *Muhlenberg co*

12 MAIDEN NAME OF MOTHER *Pearl Danks*

13 BIRTHPLACE OF MOTHER (State or country) *Muhlenberg co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Willie Fulkerson*

(Address) *Leipers*

15 Filed *Dec 7 1917* REGISTRAR *L. B. Heskett*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 7 1917*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191....., to 191....., that I last saw h..... alive on 191..... and that death occurred on the date stated above at m. The CAUSE OF DEATH* was as follows:

Had no Doctor
..... (Duration) yrs. mos. ds.

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

(Signed) M. D. 191..... (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 *Suburban P.O.* DATE OF BURIAL *Dec 7 1917*

20 UNDERTAKER *O. L. Roak* ADDRESS *Greenville K*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY IN 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.