Form V. S. 1—50m—10-23-25

**COMMONWEALTH OF KENTUCKY**
State Board of Health
BUREAU OF VITAL STATISTICS
**CERTIFICATE OF DEATH**

Dr. Axgabite

File No. 6962

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. Graham

Registration District No. 1092 1096

Registered No.

Inc. Town

Primary Registration District No. XXY

City

(No. St., Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jack Gibson

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (Write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH: 1864 (Month) (Day) (Year)

7 AGE: 63 yrs. mos. ds. IF LESS than 1 day hrs. or min?

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farm tenant
(b) General nature of industry, business or establishment in which employed (or employer)

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: "

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 (Informant) Jack Wells
(Address) McHenry, Kentucky

15 Filed 3/11/27 19 C. R. Wickliffe Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH 3/9, 1927 (Month) (Day), 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1927, to Mch 9, 1927, that I last saw him alive on Mch 9, 1927, and that death occurred on the date stated above at 10 P.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) B. G. Axgabite, M. D.

, 19 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL: Unity

DATE OF BURIAL: 3/11, 1927

20 UNDERTAKER: [illegible signature]

ADDRESS: Greenville, Ky.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH 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.