

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

30373

## 1 PLACE OF DEATH

County TrumbullVol. No. # 833Registration District No. 4825-1090Inc. Town DunmorePrimary Registration District No. 1090City Ky. (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_2 FULL NAME Domine May Green

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 Female 4 COLOR OR RACE White 5 Single Married Widowed or Divorced (Write the word)

6 DATE OF BIRTH June 28 1925  
(Month) (Day) (Year)

7 AGE 1 yrs. 5 mos. 27 ds. IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

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

9 BIRTHPLACE (State or country) Ky.

10 NAME OF FATHER Sheridan Green

11 BIRTHPLACE OF FATHER (State or country) Ky.

12 MAIDEN NAME OF MOTHER Rozina Hunt

13 BIRTHPLACE OF MOTHER (State or country) Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sheridan Green

(Address) Dunmore Ky.

15 Filed 12-25-1925 Wattie B. Bewley Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 25, 1925  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12-22, 1925, to 12-24, 1925, that I last saw her alive on 12-24, 1925, and that death occurred on the date stated above at \_\_\_\_\_ M.

The CAUSE OF DEATH\* was as follows:

Gastritis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) E. M. Bewley, M. D.  
(Address) Rosewood 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 \_\_\_\_\_ 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 Rosewood Ky. DATE OF BURIAL 26-12-1925

20 UNDERTAKER Mrs. E. J. Hargrader ADDRESS Lewisburg Ky.

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.

MAKER RESERVED FOR EXHIBIT