

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

1 PLACE OF DEATH

County *Muhlenburg*Vot. Prec. *Perred*Ino. Town *—*City *—*Registration District No. *7128*Primary Registration District No. *—*(No. *—* St., *—* Ward)2 FULL NAME *William Thos Green*12415
File No. *11394*
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 *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *single*6 DATE OF BIRTH *Sep 26, 1891*
(Month) (Day) (Year)7 AGE *28 yrs 7 mos 2 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)9 BIRTHPLACE (State or country) *Muhlenburg Co Ky*10 NAME OF FATHER *R G Green*11 BIRTHPLACE OF FATHER (State or country) *Muhlenburg Co*12 MAIDEN NAME OF MOTHER *Ellis Scipworth*13 BIRTHPLACE OF MOTHER (State or country) *Muhlenburg Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. H. Latham*(Address) *Drewry*

15

Filed *May 10, 1920* *Heinie B. Bewley*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April 30, 1920*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *one wk*, 191..., to *—*, 191..., that I last saw him alive on *April 15, 1920*, and that death occurred on the date stated above at *8 P. m.* The CAUSE OF DEATH* was as follows:*Tuberculosis of spine*(Duration) *1 yrs 6 mos* ds.

Contributory (SECONDARY)

(Duration) *—* yrs. *—* mos. *—* ds.(Signed) *J. G. Turner*, M. D.*May 1, 1920* (Address) *Turner*

*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 *Rosewood* DATE OF BURIAL *5/2, 1920*20 UNDERTAKER *Sollan Rector* ADDRESS *Drewry*

MARGIN RESERVED FOR ENDORS

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.