FORM V S 1-500M 2-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34365

File No. .....

Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. Center

Reg. Dist. No. 871

Ino. Town .....

Prim. Reg. Dist. No. 7128

City ..... (No. ..... St., ... Ward)

2 FULL NAME Verda Hord

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH: Dec (Month) 11 (Day), 1917 (Year)

7 AGE: ..... yrs. ..... mos. 19 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. Ky.

PARENTS

10 NAME OF FATHER: James Hord

11 BIRTHPLACE OF FATHER (State or country): Logan Co. Ky.

12 MAIDEN NAME OF MOTHER: Pearl Rothmon

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. McCauley

(Address) Greenville Ky.

15 Filed Dec 31, 191[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 30 (Month) (Day), 1917 (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 7 A.M. The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(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: Lewisport Ky | DATE OF BURIAL: Dec. 31, 1917

20 UNDERTAKER: McDonald & Dewitt | ADDRESS: Greenville Ky

11—3184

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.