

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

23999

PLACE OF DEATH
County Muhlenberg
Vol. No. No 2
Inc. Town Brunswick
City (No. _____) (St. _____) (Ward _____)

Registration District No. 24122
Primary Registration Dist. No. _____

File No. _____
Registered No. 67

(If death occurred in a hospital or institution, give its name instead of street and number.)

FULL NAME John L. Humphrey

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>White</u>	SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>wid</u> (Write the word)
DATE OF BIRTH <u>December 25th 1885</u> (Month) (Day) (Year)		
AGE <u>80</u> yrs. <u>8</u> mos. <u>18</u> ds. IF LESS than 1 day... hrs. or... min.?		

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

BIRTHPLACE (State or country) Muhlenberg County Ky

PARENTS	10 NAME OF FATHER <u>George Humphrey</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Ohio County - Ky</u>
	15 MAIDEN NAME OF MOTHER <u>Sallie N. Humphrey</u>
	16 BIRTHPLACE OF MOTHER (State or country) <u>Muhlenberg County Ky</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Red Cross
(Address) Central City Ky

15 Filed Sept 12, 1914 Mc Grundy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Sept 12th 1914
(Month) (Day) (Year)

11 I HEREBY CERTIFY, that I attended _____ from Sept 9th 1914 to Sept 12th 1914, that I last saw _____ alive on Sept 12, 1914 and that death occurred, on the date stated above, at 2:50 P.M.

THE CAUSE OF DEATH* is as follows: (1) Acute Nephritis and Malig.

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Chronic Nephritis
(Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Moore, M. D.
9-12-14 (Address) St. Albans Ky

*State the DISEASE CAUSING DEATH, if in deaths from VIOLENT CAUSES, and (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDE.

(18) LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSCIENTS 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 <u>Shaper Grange</u>	DATE OF BURIAL <u>Sept 13, 1914</u>
20 UNDERTAKER <u>J. B. Tucker</u>	ADDRESS <u>Brunswick</u>

WRITE PLAINLY WITH CAREFULNESS SEE THIS IS A PERMANENT RECORD
 E. S. - 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.