

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHFile No. 4807

Registered No. _____

1 PLACE OF DEATH

County MusculbegVet. ChausRegistration District No. 1099Inc. Town _____ Primary Registration District No. 6531City _____ (No. _____ St., _____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME Dw Hunter

(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 Widowed
Married
Widowed
or Divorced
(Write the word)6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6 DATE OF BIRTH Nov 24
(Month) (Day) (Year)7 AGE 70 yrs. 2 mos. 24 ds. IF LESS than 1
day _____ hrs.
or _____ min?

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Farmer(b) General nature of industry,
business or establishment in
which employed (or employer) _____9 BIRTHPLACE (city or town)
(State or country) TennPARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Tenn
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Tenn14 (Informant) _____
(Address) _____15 Filed 2/8/28 19____ C. B. Wickliffe,
By M. Wells, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 17, 1928
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased
from _____, 19____, to _____, 19____,
that I last saw h_____ alive on _____, 19____,and that death occurred on the date stated above at 28 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(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) L. G. Casabrite, 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 Bg DATE OF BURIAL Feb 18, 192820 UNDERTAKER M B McDonald ADDRESS Greenwell Bg

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.

MARSH REGISTERED FOR KENTUCKY

Do not