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.

FORM V. S. 1-000M.

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

16570

File No. ....

1 PLACE OF DEATH

County Muh[redacted]lenbery

Vot. Pct. Mannican Ky

Inc. Town ....

City ....

Registration District No. ....

Primary Registration District No. 6080

Registered No. ....

(No. .... St., ... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Robt Eugene Jewell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Nov. (Month) 1 (Day) (Year)

7 AGE .... yrs. 8 mos. .... ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) Muhlenberg Ky

PARENTS

10 NAME OF FATHER Jessie Jewell

11 BIRTHPLACE OF FATHER (State or country) Muhlenberg Ky

12 MAIDEN NAME OF MOTHER Miller

13 BIRTHPLACE OF MOTHER (State or country) Hopkins Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Jewell

(Address) Mannican

15

Filed 6/19, 1922 A C Hacker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 (Month) 18 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6-1-, 1922, to 6-18, 1922, that I last saw him alive on 6-16, 1922, and that death occurred on the date stated above at 6 P. m. The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) .... yrs. .... mos. 8 ds.

Contributory (SECONDARY) Whooping cough

(Duration) .... yrs. 1 mos. .... ds.

(Signed) F. H. Foley, M. D.

.........., 191.. (Address) Central City 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 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 New Hope

DATE OF BURIAL 6 mo 19, 1922

20 UNDERTAKER E. [redacted] Divens

ADDRESS Island Ky

11-8100