

16598

FORM 12-1-1908 2-23-12

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

PLACE OF DEATH

County Muhlenburg

Vol. No.

Registration District No. 187

File No.

Inc. Town

City Central City KyPrimary Registration District No. 2435Registered No. 22

City

No.

Second

St.

Ward

FULL NAME

Mr. A. R. Kitley
 (If death occurred in a  
 hospital or institution,  
 give the name and number of  
 ward and number.)

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE, MARRIED, WIDOWED, OR SEPARATED (Write the word) <u>married</u>
DATE OF BIRTH <u>Mar 21</u> , 18 <u>61</u> (Month) (Day) (Year)		
AGE <u>61</u> yrs. .... mos. .... ds. IF LESS than 1 day... yrs. or... mths.?		

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

9 BIRTHPLACE (State or country)  
Ky

10 NAME OF FATHER  
Philip Spence

11 BIRTHPLACE OF FATHER (State or country)  
Ky

12 MAIDEN NAME OF MOTHER  
Sarah Hudson

13 BIRTHPLACE OF MOTHER (State or country)  
Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant).....  
(Address).....

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
June 16, 1922  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1922, to June 16, 1922, that I last saw him alive on June 16, 1922, and that death occurred on the date stated above at 7 P.M. The CAUSE OF DEATH\* was as follows:

Chronic Parenchymatous Nephritis  
 (Duration)..... yrs. .... mos. .... ds.

Contributory (SECONDARY).....  
 (Duration)..... yrs. .... mos. .... ds.  
 (Signed) James Westburne, M. D.  
 (Address) Central City Ky

\*State the DISEASE CAUSING DEATH, or, in deaths from Violence, Cause and site (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.  
 15 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 <u>Harmon</u>	DATE OF BURIAL <u>June 17</u> , 19 <u>22</u>
20 UNDERTAKER <u>Master Moore</u>	ADDRESS <u>Central City Ky</u>

15 Filed 7/14/22 A. L. Dandridge  
REGISTRAR

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

E. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be in plain terms, so that it may be properly identified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.