

22923

Form V. 2, 1-15-24-2-13-13

 COMMONWEALTH OF KENTUCKY
 State Board of Health
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
File No. *1*Registered No. *[blacked out]*

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

 1 PLACE OF DEATH
 County *Muhlenberg*
 Vol. Pat. *# 24*
 Inc. Town *Medland*
 City _____ (No. _____ St. _____ Ward _____)

 Registration District No. *107A*
 Primary Registration District No. *6.845*
2 FULL NAME *Mary L. Kittinger*

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX *Female* 4 COLOR OR RACE *White* 5 Single *Married*
 Widowed *Divorced*
 (Write the word)

 6 DATE OF BIRTH *Aug. 30 1924*
 (Month) (Day) (Year)

 7 AGE *68 yrs. 1 mos. 17 ds.* IF LESS than 1
 day or _____ min?

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

 9 BIRTHPLACE (State or country) *Indiana*

 10 NAME OF FATHER *H. H. Duesley*

 11 BIRTHPLACE OF FATHER (State or country) *Indiana*

 12 MAIDEN NAME OF MOTHER *Haltzman*

 13 BIRTHPLACE OF MOTHER (State or country) *Indiana*

 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Andrew Kittinger*
Medland Ky
 (Address)

 Filed *10/29*, 1922 *C. R. Robertson*
 Registrar

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH *Oct. 16 1922*
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from _____, 192____, to _____, 192____, that I last saw h_____ alive on _____, 192____, and that death occurred on the date stated above at *9:20* a.m.

 The CAUSE OF DEATH* was as follows:
Myocardial infarction of recent antea-
rior origin, probably due to
arteriosclerosis of the
coronary arteries. Medland
 (Duration) _____ yrs. _____ mos. _____ ds.

 Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) *Lesly Young, M.D.*
 192____ (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 _____ in the State _____ yrs. _____ mos. _____ d. Where was disease contracted,

If not at place of death? Former or usual residence _____

 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Cedar Grove *10/18/1922*

 20 UNDERTAKER ADDRESS
J. B. Tucker *Bremen Ky*