

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

1 PLACE OF DEATH

County Wm. Henry

Vot. Pot. Wm. Henry

Ino. Town.....

City Depoy

2 FULL NAME Lucile F. Cook

Registration District No. 871

Primary Registration District No. 7133

(No. .... St., ..... Ward)

File No. 9559

Registered No. ....

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

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 6, 1920  
(Month) (Day) (Year)

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

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

9 BIRTHPLACE (State or country) Wm. Co Ky

10 NAME OF FATHER E. Cook

11 BIRTHPLACE OF FATHER (State or country) Wm. Co Ky

12 MAIDEN NAME OF MOTHER H. Beverly

13 BIRTHPLACE OF MOTHER (State or country) Wm. Co Ky

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

(Address) Depoy Ky

15 Filed Apr 10, 1920 C. F. Croft REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH March 11, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1920 to March 9, 1920 that I last saw h. alive on March 10, 1920 and that death occurred on the date stated above at 8 a.m. The CAUSE OF DEATH\* was as follows:

Comp. in pneumonia  
(Duration) ..... yrs. .... mos. .... ds.

Contributory (SECONDARY) ..... (Duration) ..... yrs. .... mos. .... ds.

(Signed) B. G. Argabrite, M. D. March 11, 1920 (Address) Depoy 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 Depoy Ky DATE OF BURIAL 3/12, 1920

20 UNDERTAKER C. F. Croft ADDRESS Depoy Ky

MARGIN RESERVED FOR ENDING WRITE PLAINLY IN 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.