

COMMONWEALTH OF KENTUCKY  
State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

18357

3 FRAMES OF SHADE

County MuhlenbergVet. Post East BoggsRegistration District No. 1093

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

Inc. Town \_\_\_\_\_

Primary Registration District No. 6832

City \_\_\_\_\_

(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME Jana Ruth Lovell

(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 <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single Married Widowed or Divorced <u>Widow</u> (Write the word)
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5a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH May 19, 1838  
(Month) (Day) (Year)7 AGE 90 yrs. 1 mos. 7 ds.  
IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or Housework particular kind of work \_\_\_\_\_

(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) Muhlenberg Co., Kentucky

## PARENTS

10 NAME OF FATHER Thomas Morgan11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Kentucky12 MAIDEN NAME OF MOTHER Earle13 BIRTHPLACE OF MOTHER (city or town) Kentucky  
(State or country)14 (Informant) Mrs. Nora Nord  
(Address) Greenville, Kentucky15 Filed July 30 1928 O. D. Whiffle  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 25, 1928, 19\_\_\_\_  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1928, to June 25, 1928, that I last saw her alive on June 20, 1928, and that death occurred on the date stated above at 2:30 P. The CAUSE OF DEATH\* was as follows:  
Chronic Interstitial Nephritis(Duration) 3 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? no Date of \_\_\_\_\_Was there an autopsy? noWhat test confirmed diagnosis? Urinalysis(Signed) Charles E. Mason, M. D.7/25, 1928 (Address) Greenville, Ky.

\*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 Evergreen Cemetery  
Greenville, Ky.DATE OF BURIAL June 26, 192820 UNDERTAKER Oren L. Roark ADDRESS Greenville, Ky.

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.

SAMPLE SENT TO THE STATE BOARD OF HEALTH