

MARGIN RESERVED FOR BINDING
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. 1-2002. 10-10-10

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

PLACE OF DEATH
County Mt. Vernon
Vol. Pat. No. 6
Inc. Town Island 119 Primary Reg Dist No 670# File No. 735 7549
City _____ (No. _____) (Month) _____ (Day) _____ (Year) Registered No. 7
St. _____ (Ward) _____
FULL NAME Mrs. Pearl Maddox [If death occurred in a hospital or institution, give the NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

1 SEX Female 4 COLOR OR RACE White 5 MARRIAGE Married
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH _____ 1917
(Month) _____ (Day) _____ (Year)

7 AGE _____ If LESS than
24 yrs. 2 mos. 9 ds. 1 day... hrs. 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) Murksburg, Ky

PARENTS
10 NAME OF FATHER A. Benson
11 BIRTHPLACE OF FATHER (State or country) Butler Co. Ky
12 MAIDEN NAME OF MOTHER Martie Andrew
13 BIRTHPLACE OF MOTHER (State or country) South W. Va. Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lacey Andrew
(Address) S. D. _____ Ky

15
Filed at Apr. 2, 1917 W. M. Shacklett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH March 31, 1917
(Month) _____ (Day) _____ (Year)

11 I HEREBY CERTIFY, That I attended deceased from March 15, 1917 to March 30, 1917, that I last saw her alive on March 30, 1917, and that death occurred, on the date stated above, at home.

The CAUSE OF DEATH* was as follows:

Consumption
(Duration) 1 yrs. 3 mos. 0 ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. J. Adams M. D.
March 31, 1917 (Address) Island Ky

*PRINT THE DIRECT CAUSING DEATH, OR IN DEATHS FROM VIOLENT CAUSES, STATE (1) MANNER OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL

(12) LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS) _____ In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, if not at place of death? _____
Former or usual residence _____

16 PLACE OF BURIAL, OR REMOVAL Union Cemetery DATE OF BURIAL April 1, 1917
20 UNDERTAKER W. M. Stuckie ADDRESS Island Ky