

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

28755

PLACE OF DEATH

County *Wickliffe*

Vot. Pot. *Wabash*

Inc. Town *Wabash*

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

Registration District No. *7120*

Primary Registration District No.

File No.

Registered No. *44*

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

2 FULL NAME *Ray McCrecker*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *Oct 14, 1917*
(Month) (Day) (Year)

7 AGE yrs. mos. ds. IF LESS than 1 day 4 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) *Kentucky*

10 NAME OF FATHER *Lemmie Ephraim McCrecker*

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

12 MAIDEN NAME OF MOTHER *Birdie Ann Brothers*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Lemmie McCrecker*

(Address) *McNary Kay*

15 Filed *1916 7* *J. Kennedy* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 14, 1917*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct 14, 1917* to *Oct 14, 1917*, that I last saw him alive on *Oct 14, 1917*, and that death occurred on the date stated above at *2 P. m.* The CAUSE OF DEATH was as follows: *Peranatural Death*

(Duration) yrs. mos. ds.

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

(Signed) *M. M. Bailey*, M. D. *Oct 15, 1917* (Address) *White Plains, 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 *Rock Bibles Cemetery* DATE OF BURIAL *Oct 15, 1917*

20 UNDERTAKER *no undertaker* ADDRESS

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 percentage of OCCUPATION is very important. See instructions on back of certificate.

MAKER RESERVED FOR IMPROVEMENT