

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

2510

1 PLACE OF DEATH

County *Muhlenberg*Vol. *Ennis, Ky* Registration District No. *7127*Ino. Town..... Primary Registration District No. *7*

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

2 FULL NAME *Sarah A. Miller*

File No. ....

Registered No. *211*
 (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) *Widowed*

 6 DATE OF BIRTH *February 14, 1832*  
 (Month) (Day) (Year)

 7 AGE *84 yrs. 10 mos. 7 ds.* IF LESS than 1 day... hrs. or... min.?

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

 9 BIRTHPLACE (State or country) *Kentucky*

 10 NAME OF FATHER *Wm. Hudson*

 11 BIRTHPLACE OF FATHER (State or country) *Ky.*  
 12 MAIDEN NAME OF MOTHER *(not known)*

 13 BIRTHPLACE OF MOTHER (State or country) *Ky.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) *Phillip Ryan*  
 (Address) *Browder, Ky*

 15 Filed *1-18, 1917* *F. R. Hemming*  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH *December 24, 1916*  
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from *Dec. 20, 1916*, to *Dec. 24, 1916*, that I last saw her alive on *Dec. 23, 1916*, and that death occurred on the date stated above at *9 p.m.* The CAUSE OF DEATH\* was as follows:

*Erysipelas of hand and arm,*

 (Duration) ... yrs. ... mos. *7* ds.

 Contributory (SECONDARY) *Senility*

 (Duration) *10* yrs. ... mos. ... ds.

 (Signed) *H. S. Newman*, M. D.

*Dec. 24, 1916* (Address) *Drakesboro, 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, TRANSPORTS 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 *Sarrest Grove* DATE OF BURIAL *Dec. 25, 1916*

 20 UNDERTAKER *Martin Moore* ADDRESS *Central City, Ky*

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.