

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

PLACE OF DEATH

County *Mitchell*Vot. Prec. *St. Rogge*

Inc. Town

City

Registration District No. *421*Primary Registration District No. *2167*File No. *5878*

Registered No.

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

St. Ward  
FULL NAME *Mrs. Jack Mitchell*

## PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH ..... 1 .....  
(Month) (Day) (Year)

7 AGE *6.1* yrs. .... mos. .... ds. IF LESS than 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) *Ford Co. Ky*

PARENTS  
10 NAME OF FATHER *P. Henderson Scott*  
11 BIRTHPLACE OF FATHER (State or country) *X X X*  
12 MAIDEN NAME OF MOTHER *X X X*  
13 BIRTHPLACE OF MOTHER (State or country) *X X X*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Isaac Rynch*  
(Address) *Elkton Ky*

15 Filed *7/10* 191*6* *B. B. Kinschiff*  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 9 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw him ..... alive on ..... 191..... and that death occurred on the date stated above at *6 P.m.* The CAUSE OF DEATH\* was as follows:

*Tuberculosis of Lungs*

(Duration) *2* yrs. .... mos. .... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. .... mos. .... ds.  
(Signed) *John W. Counts* M. D.  
*John W. Counts*  
(Address) *Greenville, Ky*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (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. State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL *Lee Greenwood*

DATE OF BURIAL *7/10 1916*

20 UNDERTAKER *Oren L. Roark*

ADDRESS *Greenville, Ky*

MARRIAGE REGISTERED FOR MICHIGAN

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

B. 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.