

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

25285

1 PLACE OF DEATH

County Muhlenberg  
Vol. Bremen

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

Registration District No. 1086

Registered No. 22

Inc. Town \_\_\_\_\_ Primary Registration District No. 6813

City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James A. Moore

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Married  
Married  
Widowed  
or Divorced  
(Write the word)

6a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_

7 DATE OF BIRTH Nov 28 1923  
(Month) (Day) (Year)

7 AGE 57 yrs. 10 mos. 23 ds.  
IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work Lobaria Miner  
(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_

PARENTS  
10 NAME OF FATHER  Jesse Moore  
11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_  
12 MAIDEN NAME OF MOTHER  Susan Phillips  
13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) \_\_\_\_\_

14 (Informant) Wm. A. Moore  
(Address) Bremen Ky

15 Filed Nov 10, 1931 Dollie Robertson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 28 1931  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 7<sup>th</sup>, 1921, to Sept 16, 1921, that I last saw him alive on Sept 15, 1921, and that death occurred on the date stated above at 9 AM. The CAUSE OF DEATH\* was as follows:  
Brain (Pneumonia)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory (Secondary) \_\_\_\_\_  
(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 WHERE WAS DISEASE CONTRACTED

If not at place of death? at place of death

Did an operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No

What test confirmed diagnosis? \_\_\_\_\_  
(Signed) Em. W. Harris, M. D.  
\_\_\_\_\_, 19\_\_\_\_ (Address)

\*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 Shaver's Chapel DATE OF BURIAL Oct 25, 1931

20 UNDERTAKER J. L. Peller ADDRESS Bremen 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 text that it may be properly classified. Exact percent of OCCUPATION is very important. See instructions on back of certificate.