

COMMONWEALTH OF KENTUCKY  
State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHFile No. 263651 PLACE OF DEATH  
County Muhlenberg  
Vot. Pct. Hillside  
Inc. Town  
City (No. St. Ward)Registration District No. 1093  
Primary Registration District No. XXY

Registered No.

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

2 FULL NAME Sarah Elizabeth Morris

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single single  
Married  
Widowed  
or Divorced  
(Write the word)6 DATE OF BIRTH June 26 1913  
(Month) (Day) (Year)7 AGE 3 yrs. 2 mos. 29 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) Muhlenberg Co. Ky10 NAME OF FATHER Samuel Morris11 BIRTHPLACE OF FATHER (State or country) Muh. Co. Ky12 MAIDEN NAME OF MOTHER Ira Tooley13 BIRTHPLACE OF MOTHER (State or country) Muh. Co. Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R Perry(Address) Muss. Ky15 Filed 10/4/26 C. B. Wickliffe Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25 1926  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1926, to Sept 18, 1926, that I last saw her alive on Sept 18, 1926, and that death occurred on the date stated above at 11:30 m.  
The CAUSE OF DEATH\* was as follows:Tuberculosis of Lungs  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.Contributory (Secondary)  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.(Signed) C. G. Crocker, M. D.  
Sept 26, 1926 (Address) Coates County 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 \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Where was disease contracted,if not at place of death? \_\_\_\_  
Former or usual residence19 PLACE OF BURIAL OR REMOVAL Calaman B. Co. DATE OF BURIAL Sept 26 192620 UNDERTAKER W. M. Bond ADDRESS Greenville 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 so that it may be properly classified. See instructions on back of certificate.

REPRODUCTION OF THIS FORM FOR PRIVATE USE IS PROHIBITED