

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

14231

County Ohio  
Vol. 3 Books post No 6 Registration District No. 603  
Inc. Town C. O. E. Church Primary Registration District No. 2209  
City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME Walter Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 Single MARRIED Widowed or Divorced (Write the word) <u>unmarried</u>
6 DATE OF BIRTH <u>Aug 17 1865</u> (Month) (Day) (Year)		
7 AGE <u>65</u> yrs. <u>9</u> mos. <u>24</u> ds.		IF LESS than 1 day _____ hrs. or _____ min?
8 OCCUPATION (a) Trade, profession or particular kind of work. <u>Domestic</u> (b) General nature of industry, business or establishment in which employed (or employer) <u>Domestic</u>		
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>		

PARENTS	10 NAME OF FATHER <u>Buchanan Myers</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>L.</u>
	12 MAIDEN NAME OF MOTHER <u>Jessie</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>L.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) W. J. Reid  
(Address) C. O. E. Church

15 Filed 6-16- 1922 S. T. Reid  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 14 1922  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feb 2, 1922 to June 16, 1922, that I last saw her alive on June 14, 1922, and that death occurred on the date stated above at 8 1/2 m.

The CAUSE OF DEATH\* was as follows:  
Chronic Interstitial Nephritis  
(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) W. J. Reid M. D.  
6/10/1922 (Address) C. O. E. Church

\*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  
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 Reichels Cemetery DATE OF BURIAL 6/16 1922  
20 UNDERTAKER J. C. Williams ADDRESS \_\_\_\_\_

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be 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.