

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

1 PLACE OF DEATH

County *Mushlenberg*Vol. No. *8*Registration District No. *7128*

File No.

Ino. Town *Pearce*

Primary Registration District No.

Registered No. **5872**

City

(No. St., Ward)

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

2 FULL NAME *Martha Jane Pearson*

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE *56* 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) *Key.*

10 NAME OF FATHER *Henry Jackson*

11 BIRTHPLACE OF FATHER (State or country) *Key.*

12 MAIDEN NAME OF MOTHER *Maudie Beasley*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. Jackson*(Address) *Yeast- Key.*15 Filed *2/23*, 191*6* *M. E. Beasley*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *2 23 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *2/10*, 191*6*, to *2/23*, 191*6*, that I last saw h.~~er~~ alive on *2/22*, 191*6*, and that death occurred on the date stated above at *6 a.m.* The CAUSE OF DEATH* was as follows:
Stroke Apoplexy

..... (Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) *E. M. Beasley*, M. D.
2/23, 191*6* (Address) *Pearce, Ky.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, the (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. 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 *Jackson Cem* DATE OF BURIAL *2/24*, 191*6*

20 UNDERTAKER *D. Reilor* ADDRESS *Dunmore*

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

N. B.—Every item of information should be carefully supplied. Ask 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.

MARGIN RESERVED FOR INDEXING