

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

9232

File No. \_\_\_\_\_  
Registered No. 9

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

**1 PLACE OF DEATH**County MuhlenbergVot. Pct. DrakesboroInc. Town #5

City \_\_\_\_\_ (No. \_\_\_\_\_ St., \_\_\_\_\_ Ward)

Registration District No. 10Primary Registration District No. 121**2 FULL NAME**Dovie Pogue**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b> <u>Female</u>	<b>4 COLOR OR RACE</b> <u>White</u>	<b>5 Single</b> <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced (Write the word) <u>Married</u>
<b>6 DATE OF BIRTH</b> <u>Jan 14</u> , 18 <u>84</u> (Month) (Day) (Year)		
<b>7 AGE</b> <u>39</u> yrs. <u>0</u> mos. <u>27</u> ds.		<b>IF LESS than 1 day</b> ..... hrs. <b>or</b> ..... 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) Muhlenberg Co., Ky.

<b>PARENTS</b>	<b>10 NAME OF FATHER</b> <u>John Tipton</u>
	<b>11 BIRTHPLACE OF FATHER</b> (State or country) <u>Kentucky</u>
	<b>12 MAIDEN NAME OF MOTHER</b> <u>Luda Bradley</u>
	<b>13 BIRTHPLACE OF MOTHER</b> (State or country) <u>Kentucky</u>

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) H. H. Pogue  
(Address) Drakesboro, Ky.

**15 Filed** 3/28, 1923 J. R. Kimmel  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
Feb 11, 1923  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY**, That I attended deceased from Feb 8, 1923, to Feb 11, 1923, that I last saw her alive on Feb 11, 1923, and that death occurred on the date stated above at 10 P. m.

The CAUSE OF DEATH\* was as follows:

Bronchial Asthma  
(Duration) ..... yrs. .... mos. 5 ds.  
Contributory (Secondary) Influenza  
(Duration) ..... yrs. .... mos. 7 ds.  
(Signed) A. H. Newman, M. D.  
Mar 1, 1923 (Address) Drakesboro

\*State the Disease Causing Death, or, in deaths from Violence 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 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** (Myatts) Beech Creek, Ky. **DATE OF BURIAL** Feb 12, 1923  
**20 UNDERTAKER** L. H. Stuart, Beech Creek, Ky. **ADDRESS** \_\_\_\_\_

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 language, so that it may be properly classified. Get statement of OCCUPATION in very important. See instructions on back of certificate.