

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

1 PLACE OF DEATH

County *Martin*

Vol. Pat. *Ennis #7*

Ino. Town *Drakebourn*

City *14*

Registration District No. *8728423*

Primary Registration District No. *7126*

(No. *14*) St., Ward

2 FULL NAME *A. O. Payne*

File No. *13135*

Registered No. *11*

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *Feb 8, 1885*
(Month) (Day) (Year)

7 AGE *30* yrs. *3* mos. *1* ds. IF LESS than 1 day... hrs. or... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Todd Co Ky*

10 NAME OF FATHER *J. J. Payne*

11 BIRTHPLACE OF FATHER (State or country) *Logan Co. Ky*

12 MAIDEN NAME OF MOTHER *Octavia Latham*

13 BIRTHPLACE OF MOTHER (State or country) *Todd Co Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Payne*
(Address) *Beach Creek Ky*

15 Filed *5-8, 1915* *J. H. Kinnaman*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *5 9, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct*, 1914, to *May 9*, 1915, that I last saw him alive on *May 8*, 1915, and that death occurred on the date stated above at *6:35* a.m. The CAUSE OF DEATH* was as follows:

ben. car.

(Duration) *5* yrs. *8* mos. *9* ds.

Contributory (SECONDARY) (Duration) *5* yrs. *8* mos. *9* ds.

(Signed) *S. A. Bates*, M. D.
May 9, 1915 (Address) *Drakebourn 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 of death *5* yrs. *8* mos. *9* ds. In the State *5* yrs. *8* mos. *9* ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Forest Hill* DATE OF BURIAL *5-10, 1915*

20 UNDERTAKER *H. G. Bridges* ADDRESS *Drakebourn Ky*

MARGIN RESERVED FOR INDEXING

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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.