

WRITE PLAINLY. **NEVER USE 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 terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. 1-50m-4-17-23

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. **7629**

1 PLACE OF DEATH

County **Muhlenberg**

Vot. Pct. _____ Registration District No. **1087**

Registered No. **2**

Ine. Town **Central City** Primary Registration District No. **2435**

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

2 FULL NAME **Rufus J. Penn**

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** **4 COLOR OR RACE** **White** **5 Single Married Widowed or Divorced** **Widowed**
(Write the word)

5a If married, widowed, or divorced **HUSBAND** of (or) **WIFE** of _____

6 DATE OF BIRTH **Nov 18th 1850**
(Month) (Day) (Year)

7 AGE **79** yrs. **4** mos. **0** ds. **IF LESS than 1 day** _____ hrs. _____ min?

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry, business or establishment in which employed (or employer) _____

9 BIRTHPLACE (city or town) **Kentucky**
(State or country)

PARENTS
10 NAME OF FATHER **Harris Penn**
11 BIRTHPLACE OF FATHER (city or town) **Ky**
(State or country)
12 MAIDEN NAME OF MOTHER **Barfield**
13 BIRTHPLACE OF MOTHER (city or town) **Ky**
(State or country)

14 (Informant) **Ed Penn**
(Address) **Central City Ky.**

15 Filed **3/15**, 19**30** **A. L. Bland**
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **March 14th 1930**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **Mar 14**, 19**30**, to **Mar 14**, 19**30**, that I last saw him alive on **Mar 14**, 19**30**, and that death occurred on the date stated above at **2:00** p.m. The **CAUSE OF DEATH*** was as follows:

Chronic Parenchymatous Nephritis
(Duration) **2** yrs. _____ mos. _____ ds.
Contributory _____
(Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) **Clarence H. Hordburn**, M. D.
Mar 15, 19**30** (Address) **Central City**

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL **Bethel Cemetery** **DATE OF BURIAL** **3/15 1930**

20 UNDERTAKER **Geo. Anderson** **ADDRESS** **Central City**