

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

20731

PLACE OF DEATH  
County Franklin  
Vol. No. \_\_\_\_\_  
Inc. Town \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

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

FULL NAME Reuben W Reynolds

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Aug 24, 1912  
(Month) (Day) (Year)

7 AGE 34 yrs. 9 mos. 12 ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) Jefferson Co. Ind.

PARENTS  
10 NAME OF FATHER \_\_\_\_\_  
11 BIRTHPLACE OF FATHER (State or country) Jefferson Co. Ind.  
12 MAIDEN NAME OF MOTHER Dont no  
13 BIRTHPLACE OF MOTHER (State or country) Dont no

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wife Mrs Reynolds  
(Address) Peru Ind Ky

15 Filed Aug 29, 1912  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 24, 1912  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1912, to Aug, 1912, that I last saw him alive on Aug 25, 1912, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH\* was as follows:  
Chronic Parenchymatous Nephritis  
(Duration) 3 yrs. - mos. - ds.

Contributory Dont no  
(Secondary) (Duration) - yrs. - mos. - ds.  
(Signed) J G Turner, M. D.  
Aug 24, 1912 (Address) Peru Ind

\*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 ... 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1912

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WRITE PLAINLY, WITH CORRECT SPELLING. DO NOT WRITE IN RED INK. 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.