

## COMMONWEALTH OF KENTUCKY

State Board of Health  
BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

PLACER OF DEATH  
County... *Mulhebury*  
Vot. Pct. *Beach Creek*  
Inc. Town.....  
City.....

Registration District No. *1092*Primary Registration District No. *68280*

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

2 FULL NAME *Adeline Rhoads*

File No. *16*  
Registered No. *1927*  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX.....  
4 COLOR OR RACE *negro*  
5 Single Married Widowed or Divorced (Write the word) *widow*

6 DATE OF BIRTH *may 5 1899*  
(Month) (Day) (Year)

7 AGE *70 yrs. 2 mos. 27 ds.*  
IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

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

9 BIRTHPLACE (State or country) *Greenville Ky. Mulhebury*

10 NAME OF FATHER *Louish Smith*

11 BIRTHPLACE OF FATHER (State or country) *Greenville Ky. Mulhebury*

12 MAIDEN NAME OF MOTHER *Mary Jane Smith*

13 BIRTHPLACE OF MOTHER (State or country) *Paradise Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE:

(Informant) *Ernest Rhoads*(Address) *Browder Ky*

15 Filed *9-8 1927* *Vietas J. J. Registrar*

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *8 1 1927*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *1/15/1927* to *8/1/1927*, that I last saw her alive on *8/1/1927*, and that death occurred on the date stated above at *10* m.

The CAUSE OF DEATH\* was as follows:  
*Anterior Myocardial Infarction  
of Special Etiology  
of the Coronary Artery  
of the Heart*  
(Duration) ..... yrs. .... mos. .... ds.

Contributory (Secondary) .....

(Signed) *W. H. ... M. D.*  
1927 (Address) *Greenville*

\*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 *Smith cemetery* DATE OF BURIAL *aug 3 1927*

20 UNDERTAKER *Blake Finch* ADDRESS *Draherboro*

MACHINE REPRODUCED FOR RECORDING

WRITE PLAINLY, IN 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.