

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

23666

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

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

1 PLACE OF DEATH

County MuhlenbergVot. Post NelsonRegistration District No. 1095

Inc. Town \_\_\_\_\_

Primary Registration District No. 6744

City \_\_\_\_\_

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

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

2 FULL NAME Jeanette Sharp

(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. \_\_\_\_\_ Birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single Widowed  
Married  
Widowed  
or Divorced  
(Write the word)

5a If married, widowed or divorced \_\_\_\_\_

(or) WIFE of Samuel C. Sharp6 DATE OF BIRTH April 7, 1857

(Month) (Day) (Year)

7 AGE 74 yrs. 6 mos. 13 ds.IF LESS than 1  
day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business or establishment in which employed (or employer) Retired9 BIRTHPLACE (city or town) Iowa  
(State or country)

PARENTS

10 NAME OF FATHER E. E. Rhoads11 BIRTHPLACE OF FATHER (city or town) Ohio  
(State or country)12 MAIDEN NAME OF MOTHER Rachael Rowland13 BIRTHPLACE OF MOTHER (city or town) Va.  
(State or country)

14

(Informant) Samuel Stone  
(Address) Nelson Ky.

15

Filed 11-20, 1931 Dan Napier  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 20, 1931  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1931, to Oct. 20, 1931,that I last saw him alive on Oct. 20th, 1931,and that death occurred on the date stated above at 20 m.

The CAUSE OF DEATH\* was as follows:

Basilar Pneumonia

107

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.Contributory Senility

(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) John P. Walter, M. D.Oct. 21, 1931 (Address) Central City, Ky.

\*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 NelsonDATE OF BURIAL Oct 21, 193120 UNDERTAKER Arthur S. MosbyADDRESS Central City, Ky.

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 terms so that it may be properly classified. Exact amount of OCCUPATION is very important. See instructions on back of certificate.