

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

10296

PLACE OF DEATH

County Muhlenberg

File No. _____

Vot. Pct. 25Registration District No. 1094Registered No. 235

Inc. Town _____

Primary Registration District No. 6541

City _____

(No. _____ St., _____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)2 FULL NAME Robert Franklin Shelton

(a) Residence. No. _____ St., _____ Ward. _____

(Usual place of abode)

(If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single married
Married
Widowed
or Divorced
(Write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6 DATE OF BIRTH Jan 13 1 87
(Month) (Day) (Year)7 AGE 73 yrs. 2 mos. 08 ds. IF LESS than 1
day _____ hrs.
or _____ min?8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Miner
(b) General nature of industry, business or establishment in which employed (or employer) _____9 BIRTHPLACE (city or town) Ky.
(State or country)

PARENTS
10 NAME OF FATHER William Shelton
11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)
12 MAIDEN NAME OF MOTHER Jane Greenfield
13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 (Informant) Mrs. Robert Shelton
(Address) Cleaton, Ky.15 Filed April 20, 1930 Vannie Thomas
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 22 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased
from March 1, 1930, to March 22, 1930
that I last saw him alive on March 22, 1930
and that death occurred on the date stated above at 7:30 a.m.The CAUSE OF DEATH* was as follows:
Intermittent hepatitis_____
(Duration) _____ 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) LeRoy Miller, M. D.
March 22, 1930 (Address) Cleaton, 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 DATE OF BURIAL

Friendship 3/23 193020 UNDERTAKER Arthur L. Mowley ADDRESS Cleaton, 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 statement of OCCUPATION is very important. See instructions on back of certificate.

ATTACHED