FORM V S 1-500M 2-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

# CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Muhlenburg

Vot. Pct. So. Carrollton Registration District No. 7121

Inc. Town ..... Primary Registration District No. .....

City ..... (No. ..... St., ..... Ward)

File No. 27849

Registered No. 8

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

2 FULL NAME William D. Shrewsbury

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Apr. 23, 1846 (Month) (Day) (Year)

7 AGE: 74 yrs. 4 mos. [illegible] ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Warren Co. Ky.

PARENTS

10 NAME OF FATHER: William Shrewsbury

11 BIRTHPLACE OF FATHER (State or country): Green Briar Co. Va.

12 MAIDEN NAME OF MOTHER: Rhoda P. Shrewsbury

13 BIRTHPLACE OF MOTHER (State or country): Bedford Co. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Pennie Taylor

(Address) So. Carrollton Ky.

15 Filed Dec. 9, 1921 A. C. Hacker REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. 8, 1921 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1921, to Dec. 8, 1921, that I last saw him alive on Dec. 8, 1921, and that death occurred on the date stated above at 8 A.M. The CAUSE OF DEATH* was as follows:

Tuberculosis of the Pleura & Lungs

(Duration) year or more yrs. mos. ds.

Contributory (SECONDARY) Pleurisy with Eff. & Heart Leakage - Mit. Reg. (Duration) yrs. 2 mos. ds.

(Signed) J. R. Barnes M. D.

Dec. 8, 1921 (Address) .....

*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: South Carrollton Ky

DATE OF BURIAL: Dec. 9, 1921

20 UNDERTAKER: Martin Moore

ADDRESS: Beyond Bell Ky

11—3184

MARGIN RESERVED FOR BINDING

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.