

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

1 PLACE OF DEATH

County *Muhlenberg*

Vot. Pot. *Graben*

Ino. Town *A*

City *(No)*

2 FULL NAME *Christine Simmons*

Registration District No. *(D)*

Primary Registration District No. *7140*

St. *(No)*

File No. *5700*

Registered No. *46*

(If death occurred in a hospital or institution give its name instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH *April 25, 1915*
(Month) (Day) (Year)

7 AGE *2 yrs. 6 mos. 17 ds.* IF LESS than 1 day... hrs. or... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work. *None* (b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Ky*

PARENTS

10 NAME OF FATHER *Roy Simmons*

11 BIRTHPLACE OF FATHER (State or country) *Ky*

12 MAIDEN NAME OF MOTHER *Mayme Phillips*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Virgil Robinson*
(Address) *Graben Ky*

15 Filed *11/12/17* 1917 *J. Kermeyer* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *11 12 1917*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *11/11*, 1917, to *11/12*, 1917, that I last saw *her* alive on *11/12*, 1917, and that death occurred on the date stated above at *11* m. The CAUSE OF DEATH* was as follows:
Dysphasia

(Duration) *4* yrs. *4* mos. *4* ds.
Contributory *Whooping Cough*
(SECONDARY)

(Duration) *1* yrs. *1* mos. *1* ds.
(Signed) *H. J. Edge*, M. D.
11/13, 1917 (Address) *Graben Ky*

*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 *11* yrs. *1* mos. *1* ds. in the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Robson* DATE OF BURIAL *11/12 1917*

20 UNDERTAKER *Ch. Croft* ADDRESS *Robson*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. M. D.—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.