FORM V. S. 1-500M. 6-20-11

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

File No. 24736
Registered No.

1 PLACE OF DEATH
County Muhlenberg
Vot. Pot. Paradise
Inc. Town
City
Registration District No. 7176
Primary Registration District No. 6
(No. St., Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

DELAY

2 FULL NAME Isadore G. Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Dec 6, 1844 (Month) (Day) (Year)

7 AGE: 71 yrs. 7 mos. 19 ds. IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country): Ind

PARENTS
10 NAME OF FATHER: William T. Mason
11 BIRTHPLACE OF FATHER (State or country): New York
12 MAIDEN NAME OF MOTHER: Mary Ann Lane
13 BIRTHPLACE OF MOTHER (State or country): New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam T. Smith
(Address) Paradise

15 Filed 9/25, 1916 John T. Jackson, REGISTRAR
Dep.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 25, 1916 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1916, to Sept 25, 1916, that I last saw her alive on Sept 25, 1916, and that death occurred on the date stated above at 10 a.m. The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

Contributory (SECONDARY): malaria with complications

(Duration) ... yrs. ... mos. ... ds.

(Signed) G. D. Connelly, M. D.
Sept 25, 1916 (Address) Rockport

*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: Nurse Bivol
DATE OF BURIAL: 9/26, 1916

20 UNDERTAKER: J. Williams
ADDRESS: Rockport

11—3184

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD