

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

11105

1 PLACE OF DEATH

County *Muhlenberg*

Vol. No. *4*

Registration District *871*

Inc. Town

Primary Registration District No. *2130*

City

(No. St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Callie Taylor*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *Oct 18, 1905*
(Month) (Day) (Year)

7 AGE *16 yrs. 6 mos. 17 ds.* IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country) *Todd Co Mo*

PARENTS

10 NAME OF FATHER *Milton Taylor*

11 BIRTHPLACE OF FATHER (State or country) *Todd Co Mo*

12 MAIDEN NAME OF MOTHER *Katie Higgins*

13 BIRTHPLACE OF MOTHER (State or country) *Todd Co Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Katie Easter*

(Address) *Gravelle R. 3*

15 Filed *5/26/12* *W. B. Wickliffe* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 4, 1921*
(Month) (Day) (Year)

17 I HEREBY CERTIFY THAT I signed deceased from *April 29, 1921 to May 1, 1921* that I last saw her alive on *May 1, 1921* and that death occurred on the date stated above at *5 p.m.* The CAUSE OF DEATH was as follows:

Soft brain tumor
(Duration) *16 ds.*

Contributory (SECONDARY) *E. Pharyngitis*
(Duration) *1 mo.*
(Signed) *E. Pharyngitis*
(Address) *Gravelle R. 3*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, (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 *16 ds.* in the State *Mo.*

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

19 PLACE OF BURIAL OR REMOVAL *Hettely Bldg.* DATE OF BURIAL *May 5, 1921*

20 UNDERTAKER *McDonald & Smith* ADDRESS *Gravelle R. 3*

WRITE PLAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD
B. 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.