

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHFile No. 17776Registered No. 52

1 PLACE OF DEATH

County Jackson

Vot. Pct. _____

Registrar District No. 1087Ine. Town Central CityPrimary Registration District No. 2435

City _____

(No. _____ St. _____ Ward)

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

2 FULL NAME

Ben Thurman Jr 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 Widowed or Divorced (Write the word) Single5a Is married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6 DATE OF BIRTH June 22 - 1929
(Month) (Day) (Year)7 AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day _____ hrs. or _____ min?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9 BIRTHPLACE (city or town) (State or country)

PARENTS
10 NAME OF FATHER Ben Thurman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky
12 MAIDEN NAME OF MOTHER Maude Griffith
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky14 (Informant) Ben Thurman
(Address) Central City Ky15 Filed 6-23-29 1929 - A.L. Bradford
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22th 1929
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 22, 1929, that I last saw him alive on June 22, 1929, and that death occurred on the date stated above at 4:30 p.m.
The CAUSE OF DEATH* was as follows:
Premature Birth(Duration) _____ yrs. _____ mos. _____ ds.
Contributory 6 1/2 mo Gestation
(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) Dr. P. Trotter M. D.June 23 1929 (Address) Central City 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 Kindness Bluff DATE OF BURIAL 6/24/2920 UNDERTAKER E. J. Anderson ADDRESS Central City

WRITE PLAINLY, 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.

WAGNER REGISTERED JOB BINDER