

Form V. S. 1-A

## COMMONWEALTH OF KENTUCKY

State Board of Health  
BUREAU OF VITAL STATISTICS

File No. ....

PLACE OF DEATH

County Muhlenberg

## CERTIFICATE OF DEATH

Registered No. ....

County MuhlenbergRegistration District No. 1093

Ina. To

Primary Registration District No. 2436City Greenville Ky(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)2. FULL NAME Jessie May Walker(a) Residence, No. \_\_\_\_\_ 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 F 4. COLOR OR RACE W 5. Single, Married, Widowed  
or Divorced (write the word) Married5a.  married, widowed, or divorced  
HUSBAND of  
(or) WIFE of6. DATE OF BIRTH Nov. 3 18927. AGE Years Months Days IF LESS than  
41 11 4 1 day ..... hrs.  
or ..... min.8. Trade, profession, or particular  
kind of work done, as spinner,  
conyer, bookkeeper, etc. Practical Nurse9. Industry or business in which  
work was done, as silk mill,  
sawmill, bank, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE Ky13. NAME D. W. Hill14. BIRTHPLACE Ky15. MAIDEN NAME Alice Atkinson16. BIRTHPLACE Ky17. INFORMANT Chas. Walker(Address) Greenville Ky18. ~~BIRTH~~ INFORMATION, OR REMOVAL Hopkewille Ky

Place \_\_\_\_\_ Date \_\_\_\_\_

19. UNDERTAKER Greenville Funeral Home

(Address) \_\_\_\_\_

20. FILED 10-P 34 R. P. Compher

Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct. 7, 193422. I HEREBY CERTIFY, That I attended deceased from  
\_\_\_\_\_ to \_\_\_\_\_, 1934 to Oct 6, 1934.I last saw her alive on Oct 6, 1934, death is said  
to have occurred on the date stated above, at 11:30 am.  
The principal cause of death and related causes of importance  
in order of onset were as follows:Pulmonary Tuberculosis Date of  
onsetContributory causes of importance not related to  
principal cause:Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_23. If death was due to external causes (violence) fill in also the  
following:  
Accident, suicide, or homicide? \_\_\_\_\_ date of injury \_\_\_\_\_ 10 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in  
public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of  
deceased? \_\_\_\_\_ If so, specify \_\_\_\_\_(Signed) E. K. Yates, M. D.(Address) Greenville Ky

MARGIN RESERVED FOR BINDING

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificate.