

## COMMONWEALTH OF KENTUCKY

State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHFile No. **18668**

## 1 PLACE OF DEATH

County *Muhlenberg*Vet. Pat. *Wain House*

Inc. Town

City

Registration District No. *1093*Primary Registration District No. *6830*

(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

2 FULL NAME *Jesse Wells*

Registered No. \_\_\_\_\_

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single  Married  Widowed  or Divorced   
(Write the word)6 DATE OF BIRTH *Dec 28*  
(Month) (Day) (Year)7 AGE *32* yrs. *6* mos. *13* ds.  
IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?8 OCCUPATION  
(a) Trade, profession or particular kind of work *Farming*  
(b) General nature of industry, business or establishment in which employed (or employer)9 BIRTHPLACE (State or country) *Muhlenberg Co. Ky.*10 NAME OF FATHER *Ellis Wells*11 BIRTHPLACE OF FATHER (State or country) *Muh. Co. Ky.*12 MAIDEN NAME OF MOTHER *Nannie Jackson*13 BIRTHPLACE OF MOTHER (State or country) *Muh. Co. Ky.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Earl Wells*  
(Address) *Greenville Ky. R. 3*15 Filed *7/12/26* *Bedrick* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 11, 1926*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *June 24, 1926*, to *July 11, 1926*, that I last saw him alive on *July 9, 1926*, and that death occurred on the date stated above at *1 p.m.*The CAUSE OF DEATH\* was as follows:  
*Tubercular meningitis*Contributory (Secondary) *Pulmonary tuberculosis*  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) *S. O. Whitaker* M. D.  
*July 12, 1926* (Address) *Greenville, 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 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted,if not at place of death?  
Former or usual residence19 PLACE OF BURIAL OR REMOVAL *Cherry Grove 034* 20 DATE OF BURIAL *July 12, 1926*  
21 UNDERTAKER *M B McDonald* ADDRESS *Greenville*