

copy

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

PLACE OF DEATH

County Muhlenberg

Vot. Pot. ....

Inc. Towns .....

City Central City (No. .... St.; Ward) .....FULL NAME Lucania Jane WelbyFile No. 18385

Registered No. ....

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Negro</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>
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6 DATE OF BIRTH <u>Do not know</u>	1 (Month) (Day) (Year)
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7 AGE <u>Do not know</u>	If LESS than 1 day.... hrs., or.... min.?
.... yrs. .... mos. .... ds.	

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

9 BIRTHPLACE (State or country) Muhlenberg County Ky

PARENTS	10 NAME OF FATHER <u>Do not know</u>
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PARENTS	11 BIRTHPLACE OF FATHER (State or country) <u>Do not know</u>
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PARENTS	12 MAIDEN NAME OF MOTHER <u>Do not know</u>
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PARENTS	13 BIRTHPLACE OF MOTHER (State or country) <u>Do not know</u>
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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. W. P. Welby  
(Address) Central City, Ky15 Filed Jan. 24, 1911 B. B. Bree  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January - 24 - 1911  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1910, to January 28, 1911, that I last saw her alive on Jan. 23, 1911, and that death occurred, on the date stated above, at 5 a.m.  
The CAUSE OF DEATH\* was as follows:

Tuberculosis

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

Contributory Old age  
(SECONDARY) (Duration) .... yrs. .... mos. .... ds.(Signed) W. P. Doewelt, M. D.  
(Address) Central City, Ky, 1911

\*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 Train Tunnels DATE OF BURIAL Jan. 25, 191120 UNDERTAKER Marion Moore ADDRESS .....

DELAY

NOTE: 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.