

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

1 PLACE OF DEATH  
 Court *Franklinburg*

Vot. Pot. *5* Registration District No. *878*

Inc. Town *Drakebros* Primary Registration District No. *7185*

City (No. St., Ward)

2 FULL NAME *Ada White*

File No. *21286*  
 Registered No.

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

6 DATE OF BIRTH *11-17, 1888*  
(Month) (Day) (Year)

7 AGE *29* yrs. *4* mos. *19* 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)

9 BIRTHPLACE (State or country) *Duncan Ky*

10 NAME OF FATHER *John Reno*

11 BIRTHPLACE OF FATHER (State or country) *Don't know*

12 MAIDEN NAME OF MOTHER *Liddie Menden*

13 BIRTHPLACE OF MOTHER (State or country) *Don't know*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Ada White*

(Address) *Drakebros 14*

15 Filed *8/19, 1918* *J. H. Kinnaman* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH *8 17, 1918*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 21, 1918*, to *Aug 17, 1918*, that I last saw her alive on *July 21, 1918*, and that death occurred on the date stated above at *2 P.M.* The CAUSE OF DEATH\* was as follows:

*apoplectic*  
 (Duration) yrs. mos. ds.

Contributory (secondary) (Duration) yrs. mos. ds.

(Signed) *L. A. Carter*, M. D. *Aug 19, 1918* (Address) *Drakebros*

\*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 *Roadside* DATE OF BURIAL *8/19, 1918*

20 UNDERTAKER *Louis Street* ADDRESS *Beck Street*

MAILED RECEIVED FOR RECORDS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 M. D.—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.