Form V. S. 1—50m—10-23-25

COMMONWEALTH OF KENTUCKY
State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 10771
Registered No. 11

1 PLACE OF DEATH
County Muhlenburg
Vot. Pct. Dr. Carrollton
Registration District No. 1085
Inc. Town
Primary Registration District No. 2195
City
(No. D, St., Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Kathleen Duckliffe

(a) Residence. No. South Carrollton 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.

DELAY

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Col
5 Single, Married, Widowed or Divorced (Write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH
(Month) (Day) 1 (Year)

7 AGE: 92 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): Coffee Co Tenn

PARENTS

10 NAME OF FATHER: Bill Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country): Coffee Co Tenn
12 MAIDEN NAME OF MOTHER: Ann Jones
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Coffee Co Tenn

14 (Informant): Andy Duckliffe
(Address): Dr. Carrollton

15 Filed 3/19, 1925 A.C. Hocker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 13, 1925
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March, 1925, to March 13, 1925, that I last saw her alive on 13th March, 1925, and that death occurred on the date stated above at 7 a.m.
The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) yrs. mos. 12 ds.
Contributory (Secondary) Pelvic Pleurisy
(Duration) 1 yrs. mos. ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual test
(Signed) W. W. Bailey, M. D.
March 13, 1925 (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: Dr. Carrollton Cemetery
DATE OF BURIAL: March 14, 1925
20 UNDERTAKER: Ed Gage
ADDRESS: Central City Ky

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated 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.

MARGIN RESERVED FOR BINDING