FORM V. S. (-300 M. 10-16-15

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

870
2435

File No. 27596

Registered No. 44

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

1 PLACE OF DEATH
County Muhlenberg
Vot. Pct. .....
Inc. Town Central City
City ..... (No. ....., ... St., ... Ward)

2 FULL NAME Clara Woodburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single
6 DATE OF BIRTH: 10 (Month) - 12 (Day), 1911 (Year)
7 AGE: 3 yrs. 0 mos. 14 ds. If LESS than 1 day .... hrs, or .... min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry business, or establishment in which employed (or employer): .....
9 BIRTHPLACE (State or country): Central City Ky

PARENTS
10 NAME OF FATHER: D. A. Woodburn
11 BIRTHPLACE OF FATHER (State or country): Muhlenburg Co Ky
12 MAIDEN NAME OF MOTHER: Annie Henry
13 BIRTHPLACE OF MOTHER (State or country): Muhlenburg Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. A. Woodburn
(Address) Central City Ky

15 Filed Dec. 10, 1914 A. L. Blandford Registrar

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 26 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1914, to Oct 26, 1914, that I last saw her alive on Oct 26, 1914, and that death occured, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Enteritis
.....
.....
.....
(Duration) ..... yrs. 6 mos. ..... ds.
Contributory (Secondary) Typhoid fever
(Duration) ..... yrs. 1 mos. 15 ds.

(Signed) J. W. Tarrant, M. D.
Oct 26, 1914 (Address) Central City 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 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: Fairmount Cemetery
DATE OF BURIAL: Oct. 27, 1914
20 UNDERTAKER: Martin Moore
ADDRESS: Central City

N. B.—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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD