FORM V. S. 1-100 M-1-10-11.

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

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

Registration District No. 870
Primary Registration Dist. No. 2435
File No. 43152
Registered No. 43

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

2 FULL NAME James Taylor Woodburn

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH: Dec 25, 1848 (Month) (Day) (Year)

7 AGE: 65 yrs. 10 mos. 7 ds. If LESS than 1 day ____ hrs, or ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry business, or establishment in which employed (or employer): ____

9 BIRTHPLACE (State or country): Christian Co Ky

PARENTS
10 NAME OF FATHER: James Taylor Woodburn
11 BIRTHPLACE OF FATHER (State or country): Christian Co Ky
12 MAIDEN NAME OF MOTHER: Amelia Heggins
13 BIRTHPLACE OF MOTHER (State or country): North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Coffman
(Address) Central City Ky

15 Filed Nov 3, 1914 A. L. Blandford Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 2nd (Month) (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Nov 2, 1914, that I last saw him alive on Nov 1, 1914, and that death occured, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Organic heart lesion
____
____
Chronic (Duration) ____ yrs. 10 mos. ____ ds.
Contributory (Secondary) Bright's Disease
(Duration) 2 yrs. ____ mos. ____ ds.

(Signed) Jo M Ferguson, M. D.
Nov 2, 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: Nov 3, 1914

20 UNDERTAKER: Martin Moore
ADDRESS: Central City Ky

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

E. B.—Every item of information should be carefully supplied. ALL should be stated EXACTLY. PERSONS making false CAUSE OF DEATH is prima facie proof, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11—6196