

1 PLACE OF DEATH

County *Muttenburg*

Vot. Pot. *75*

Ino. Town. *Drakesboro Ky*

City

2 FULL NAME

*Sabie L. Campfield*

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

Registration District No. *829*

Primary Registration District No. *7125*

(No. *36092* St. *66* Ward)

36092

File No. ....

Registered No. *66*

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

**DELAY**

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *1886*  
(Month) (Day) (Year)

7 AGE *32* yrs. .... mos. .... ds. IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country) *Butler Co. Ky*

10 NAME OF FATHER *Taylor McKenney*

11 BIRTHPLACE OF FATHER (State or country) *Butler Co Ky*

12 MAIDEN NAME OF MOTHER *Martha E. Buby*

13 BIRTHPLACE OF MOTHER (State or country) *Warren Co. Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *E. W. McKenney* (Address) *Drakesboro, Ky*

15 Filed *11/12, 1918* J. K. Kimmel REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 28, 1918*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct 27, 1918*, to *Oct 28, 1918*, that I last saw her alive on *Oct 28, 1918*, and that death occurred on the date stated above at *7:59* a.m. The CAUSE OF DEATH\* was as follows:

*Lobar Pneumonia*

(Duration) .... mos. .... ds. Contributory (SECONDARY) *Spanish Influenza* (Duration) .... yrs. .... mos. .... ds. (Signed) *H. D. Newman* *Nov. 7, 1918* (Address) *Drakesboro 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. State .... yrs. .... mos. .... ds. Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Drakesboro Ky* DATE OF BURIAL *Oct 29, 1918*

20 UNDERTAKER *E. W. McKenney* ADDRESS *Drakesboro Ky*

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

N. B.--Every item of information should be carefully supplied. Ask 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.