

1 PLACE OF DEATH

STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County *Muhlenberg*

Vot. Pot. *West Poygan*

Ino. Town

City *Deport* (No. St., Ward)

Registration District No. *871*

Primary Registration District No. *7130*

File No.

Registered No.

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

2 FULL NAME *Mollie Coorbin*

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 *Nov 1864*
(Month) (Day) (Year)

7 AGE *53 8*
... yrs. ... mos. ... 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) *Ky*

PARENTS

10 NAME OF FATHER *Mathis*

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

12 MAIDEN NAME OF MOTHER *Allen*

13 BIRTHPLACE OF MOTHER (State or country) *Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jessie Mathis*
(Address) *Deport Ky*

15 Filed *7/16, 1918*
O. B. Wiedel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 14 1918*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *7-27, 1918*, to *7-14, 1918*,

that I last saw *her* alive on *7-14, 1918*, and that death occurred on the date stated above at *.....* m. The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

..... (Duration) yrs. mos. ds.

Contributory (SECONDARY)

..... (Duration) yrs. mos. ds.

(Signed) *H. F. Luton*, M. D.

7-14, 1918 (Address) *Grandville Ky*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, 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 *Epinger Bl.* DATE OF BURIAL *7/15, 1918*

20 UNDERTAKER *Thomas Murph* ADDRESS *Deport*

WRITE PLAINLY WITH INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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.