

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

9/27/16

File No. **21580**

1 PLACE OF DEATH

County **Muhlenberg**

Vot. Pot. **E. Boyers**

Registration District No. **871**

Ino. Town..... Primary Registration District No. **7132**

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

2 FULL NAME **Chas. B. Randolph**

Registered No.....

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX **Male** 4 COLOR OR RACE **white** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Widowed**
(Write the word)

16 DATE OF DEATH **Aug. 20, 1916**
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, That I attended deceased from **June 11, 1916**, to **June 18, 1916**, that I last saw him alive on **June 20, 1916**, and that death occurred on the date stated above at **5 P.M.** The CAUSE OF DEATH* was as follows:

7 AGE **81** yrs..... mos..... ds. IF LESS than 1 day... hrs. or... min.?

Uremia, Nephritis, Chronic Pyelitis & Prostatitis.
(Duration) **6 yr.** yrs..... mos..... ds.

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

Contributory..... (SECONDARY)..... (Duration)..... yrs..... mos..... ds.

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

(Signed) **E. P. Ahlborn** M. D. **Aug 21, 1916** (Address) **McDonnell & DeWitt**

PARENTS

10 NAME OF FATHER **Ashford Randolph**

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

12 MAIDEN NAME OF MOTHER **Garoline Bates**

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Arthur Lile**

(Address) **White Plains, R. 11**

19 PLACE OF BURIAL OR REMOVAL **Musee B.G.** DATE OF BURIAL **Aug 21, 1916**

15 Filed **8/27**, 1916 **C. B. McNeel** REGISTRAR

20 UNDERTAKER **McDonnell & DeWitt** **Greenville**

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

M. B.--Every item of information should be carefully checked. All should be entered 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.