

COMMONWEALTH OF KENTUCKY  
 State Board of Health  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

2067

County *Muhlenberg*  
 Vol. No. *M. Central City Ky*  
 Inc. Town  
 City *Central City Ky*

Registration District No. *181*  
 Primary Registration District No. *2435*

File No.  
 Registered No. *102*  
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*George C Rawling* (Rawling)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

1 SEX *male*      4 COLOR OR RACE *col.*      5 Single Married Widowed or Divorced (Write the word)  
 6 DATE OF BIRTH *July 20* 18*85*  
 (Month) (Day) (Year)  
 7 AGE *28 yrs 5 mos 4 ds.* IF LESS than 1 day \_\_\_\_ hrs. or \_\_\_\_ min?

16 DATE OF DEATH *Nov 25* 192*3*  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, That I attended deceased  
 from \_\_\_\_\_, 192\_\_\_\_, to \_\_\_\_\_, 192\_\_\_\_  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 192\_\_\_\_  
 and that death occurred on the date stated above at *2:40 P.M.*  
 The CAUSE OF DEATH\* was as follows:

8 OCCUPATION (a) Trade, profession or particular kind of work \_\_\_\_\_ (b) General nature of industry, business or establishment in which employed (or employer) *Porter Barber*  
 9 BIRTHPLACE (State or country) *Toledo Ohio*

*Knife Wounds in the Chest*  
*Instant* (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
 Contributory (Secondary) \_\_\_\_\_  
*Instant* (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
 (Signed) *R. C. Allen Egner, M.D.*  
*Dec 1st 1923* (Address) *Central City Ky*

10 NAME OF FATHER *unknown*  
 11 BIRTHPLACE OF FATHER (State or country) *unknown*  
 12 MAIDEN NAME OF MOTHER *unknown*  
 13 BIRTHPLACE OF MOTHER (State or country) *unknown*

\*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) *Fanny Rawling* (Address) *New Orleans*

19 PLACE OF BURIAL OR REMOVAL *60 Green yd.* DATE OF BURIAL *Nov 24 1923*  
 20 UNDERTAKER *Gas & Lunge* ADDRESS *Central City Ky*

15 Filed *1/8* 192*4* *A. L. Chandler* Registrar

N.B.—Every item of information should be given in plain terms so that it may be properly classified. Cause of DEATH in plain terms so that it may be properly classified. Cause of DEATH in plain terms so that it may be properly classified. Cause of DEATH in plain terms so that it may be properly classified. Cause of DEATH in plain terms so that it may be properly classified. Cause of DEATH in plain terms so that it may be properly classified.