

## COMMONWEALTH OF KENTUCKY

State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

4889

1 PLACE OF DEATH  
County Muhlenberg  
Vot. Pot. \_\_\_\_\_ Registration District No. 1087  
Inc. Town Central City Primary Registration District No. 35  
City \_\_\_\_\_ (No. D) St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nannie May Richardson  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Single  
Married  
Widowed  
or Divorced  
(Write the word)

5a If married, widowed, or divorced  
HUSBAND of \_\_\_\_\_  
(or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH Oct 22 1884  
(Month) (Day) (Year)

7 AGE 45 yrs. 3 mos. 19 ds. IF LESS than 1  
day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min?

8 OCCUPATION OF DECEASED  
(a) Trade, profession or  
particular kind of work. Sales Lady  
(b) General nature of industry,  
business or establishment in  
which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_  
(State or country) Ky.

PARENTS

10 NAME OF FATHER John H. Richardson

11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
(State or country) Ky.

12 MAIDEN NAME OF MOTHER Reta Ferguson

13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
(State or country) Ky.

14 (Informant) Mrs. J.E. Davis  
(Address) Burnsboro Ky

15 Filed 2/13, 1930 A. L. Bradford  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 10, 1930  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased  
from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
that I last saw her alive on 2-10, 1930,  
and that death occurred on the date stated above at 2 P.  
The CAUSE OF DEATH\* was as follows:  
apoplexy  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory H. D. Bussan  
(Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18 WHERE WAS DISEASE CONTRACTED  
If not at place of death? \_\_\_\_\_  
Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_  
Was there an autopsy? \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_  
(Signed) F. H. Foley M. D.  
2-11, 1930 (Address) Central City Ky

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Fairmont DATE OF BURIAL Feb 11, 1930  
20 UNDERTAKER Arthur H. Mosley ADDRESS Central City Ky

WRITE PLAINLY IN UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE 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.

NAME REMOVED FOR PRIVACY