

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

13041

1 PLACE OF DEATH

County **MUHLENBERG**

Vot. Pot. **#5** Registration District No. **872**

Ino. Town **DRAKESBORO KY.** Primary Registration District No. **7125**

City (No. St., Ward)

2 FULL NAME **LENA ROBERTSON**

File No. **13041**

Registered No. **13041**

(If born in a hospital or institution, give its name, street and number.)

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX **FEMALE** 4 COLOR OR RACE **NEGRO** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) **MARRIED**

6 DATE OF BIRTH **Feb. 28th 1872**, 1 (Month) (Day) (Year)

7 AGE **41** yrs. **11** mos. **26** 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) **Christian, Ky County Ky**

10 NAME OF FATHER **Jackson Crews,**

11 BIRTHPLACE OF FATHER (State or country) **Christian County, Ky,**

12 MAIDEN NAME OF MOTHER **Emma Harris,**

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) **BUD BOYD**

(Address) **DRAKESBORO KY.**

Filed **5/25/14** **J.R. Kennel** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH **MAY 24, 1914** (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from **MAY 22, 1914**, to **MAY 24, 1914**, that I last saw h. **alive on MAY 22, 1914**, and that death occurred on the date stated above at **11 Pm.** The CAUSE OF DEATH\* was as follows:

**TUBERCULOSIS OF BOWELS**

(Duration) **3** yrs. **3** mos. **0** ds.

Contributory (SECONDARY) (Duration) **3** yrs. **3** mos. **0** ds.

(Signed) **H.D. Newman**, M. D. **MAY 25, 1914** (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. 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 **Smith Gray Yard,** DATE OF BURIAL **May 26th, 1914**

20 UNDERTAKER **C.G. Bridges & Co** ADDRESS **Drakesboro, Ky**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. All 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.