

30365

Form V. S. 1-30m-3-4-34
1 PLACE OF DEATH

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

File No. _____
Registered No. 76

County Muhlenberg
Vol. Unknown
Inc. Town Central City
City _____ (No. _____ St., _____ Ward)

Registration District No. 1087
Primary Registration District No. 435

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single Married Widowed or Divorced Unknown
(Write the word)

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE About 30 yrs. mos. ds. IF LESS than 1 day hrs. or min?

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

9 BIRTHPLACE (State or country) Unknown

PARENTS

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

(Address) _____

15 Filed 12/29 1925 - A.L. Blufford Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 21, 1925
(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 _____m.

The CAUSE OF DEATH* was as follows:
Five Pistol wounds in Breast
Home

Instant (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R.H. Allen Evans, M.D. Dec 21, 1925 (Address) Central City 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. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____

If not at place of death? _____ Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Crematorium DATE OF BURIAL Dec 23, 1925

20 UNDERTAKER Jas E. George ADDRESS Central City Ky

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.