

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

PLACE OF DEATH  
County Madison  
Vol. Sevier 114  
Inc. Town \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.) \_\_\_\_\_ Ward \_\_\_\_\_

File No. 16475  
Registered No. \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mrs. Elias Wilkins

PERSONAL AND STATISTICAL PARTICULARS

8 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	6 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Not known</u> 1 _____ (Month) (Day) (Year)		
7 AGE <u>about 43 yrs</u> _____ yrs. _____ mos. _____ ds.		If LESS than 1 day _____ hrs. or _____ min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housekeeper</u>		
9 BIRTHPLACE (State or country) <u>Not known</u>		
PARENTS	10 NAME OF FATHER <u>Not known</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Not known</u>	
	12 MAIDEN NAME OF MOTHER <u>Not known</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Not known</u>	

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH June 14, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1913, to June 14, 1914, that I last saw him alive on June 6, 1914 and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
The CAUSE OF DEATH\* was as follows:  
Pellagra  
(Duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) J. M. Ferguson M. D.  
June 27, 1914 (Address) Crested 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. 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) A. H. Brown  
(Address) Sevier

15 Filed June 20, 1914 A. H. Brown  
REGISTRAR

19 PLACE OF BURIAL OR REMOVAL Sevier DATE OF BURIAL June 20, 1914  
20 UNDERTAKER Elias Wilkins ADDRESS Sevier

WRITE PLAINLY, WITH CAREFULNESS AND PRECISION IN A PERMANENT INK  
 Every item of information should be accurately 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.