FORM V S 1-500M 3-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No. 2551

Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. No 2 Registration District No. 2-7122

Ino. Town Bremen Primary Registration District No. 2

City ..... (No. ..... St., ... Ward)

2 FULL NAME Elias Wilkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH March 11, 1842 (Month) (Day) (Year)

7 AGE 71 yrs. 10 mos. 16 ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) Muhlenberg Co Ky

PARENTS

10 NAME OF FATHER John Wilkins

11 BIRTHPLACE OF FATHER (State or country) Muhlenberg Co Ky

12 MAIDEN NAME OF MOTHER Nancy Strubee

13 BIRTHPLACE OF MOTHER (State or country) Muhlenberg Co Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Will Wright

(Address) Midland Ky.

15 Filed Jan 28, 1914 W. L. Grimsley REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 27 (Month) (Day) 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1914, to Jan 27, 1914, that I last saw h alive on Jan 26, 1914, and that death occurred on the date stated above at 5:30 A.m. The CAUSE OF DEATH* was as follows:

A blow on the head
Fractured skull
Concussion of brain
Homicide (Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) J. J. Maguerey, M. D.

Jan 28, 1914 (Address) Bremen

*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	DATE OF BURIAL
Leader Grove	Jan 29, 1914
20 UNDERTAKER	ADDRESS
B Stuart	Bremen Ky

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

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