

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

**1 PLACE OF DEATH**County *Muhlenberg*Vot. Pct. *Graham*

Inc. Town

City

Registration District No. *1096*

Primary Registration District No.

(No. \_\_\_\_\_ St., \_\_\_\_\_ Ward)

File No. *26379*Registered No. *26379*

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

**2 FULL NAME** *J. H. Williams***PERSONAL AND STATISTICAL PARTICULARS****3 SEX***male***4 COLOR OR RACE***white***5 Single**  
Married *Widowed*  
Widowed  
or Divorced  
(Write the word)**6 DATE OF BIRTH**

(Month) (Day) (Year)

**7 AGE***84*

yrs. mos. ds.

IF LESS than 1  
day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min?**8 OCCUPATION**(a) Trade, profession or particular kind of work *None*  
(b) General nature of industry, business or establishment in which employed (or employer)**9 BIRTHPLACE**  
(State or country)*Muhlenberg Co. Ky.***10 NAME OF FATHER***Don't know***PARENTS****11 BIRTHPLACE OF FATHER**  
(State or country)*Ky***12 MAIDEN NAME OF MOTHER***Don't know***13 BIRTHPLACE OF MOTHER**  
(State or country)*.. ..***14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**(Informant) *Edgar Williams*(Address) *Graham Ky***15**Filed *10/10**1926**6**J. H. Williams**Regist**ar**1096***MEDICAL CERTIFICATE OF DEATH****16 DATE OF DEATH***Sept 14, 1926*  
(Month) (Day) (Year)**17 I HEREBY CERTIFY**, That I attended deceasedfrom *9/7*, 192*6*, to *9/14*, 192*6*,  
that I last saw him alive on *9/14*, 192*6*,  
and that death occurred on the date stated above at *50* m.

The CAUSE OF DEATH\* was as follows:

*acute myocardial infarction*(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *10* ds.Contributory  
(Secondary)

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

(Signed) *T. J. Edge*

\_\_\_\_\_, M. D.

*9/15* \_\_\_\_\_ (Address) *210 Graham 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 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. in the  
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***Williams Bg***DATE OF BURIAL***Spt 15, 1926***20 UNDERTAKER***M B McDougal Greenville*

ADDRESS

WRITE PLAINLY, WITH 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. EX- statement of OCCUPATION is very important. See instructions on back of certificate.