

M. B.—WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD. 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. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

COMMONWEALTH OF KENTUCKY
 Department of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. 17670

Registration District No. 57 Primary Registration District No. 4081

1. PLACE OF DEATH:
 (a) County BATH
 (b) City or town SALT-LICK
(If outside city or town limits, write RURAL)
 (c) Name of hospital or institution: _____
(If not in hospital or institution write street number or location)
 (d) Length of stay: In hospital or community _____
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State KY (b) County BATH
 (c) City or town SALT-LICK
(If outside city or town limits, write RURAL)
 (d) Street No. _____
(If rural give precinct)
 (e) If foreign born, how long in U. S. A. _____ years

3(a) FULL NAME BEATRICE-MAY HARDIN
 3(b) If veteran, _____ 3(c) Social Security No. _____

4. FEMALE 5. Color or race WHITE 6(a) Single, married, divorced SINGLE

6(b) Name of husband or wife _____
 6(c) Age of husband or wife if alive _____ years

7. Birth date of deceased July - 27 - 1917
(Month) (Day) (Year)

8. AGE: 27 years 5 months 13 days
If less than one day write hr.

9. Birthplace KENTUCKY
 10. Usual occupation _____
 11. Industry or business _____

FATHER
 12. Name JOE HARDIN
 13. Birthplace KENTUCKY

MOTHER
 14. Maiden name ELLA-MAY FRYE
 15. Birthplace W. V. A.

16(a) Informant's own signature Ella May Hardin
 (b) Address SALT-LICK Ky.

17. BURIAL, CREMATION, OR REMOVAL
 Place State Cem. Date Aug 15, 1944

18(a) Signature of funeral director Thomas J. Smith
 (b) Address SALT-LICK KY

19(a) Aug - 13 - 1944 (b) W. Pearl Bratter
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 - 1944
 21. I hereby certify that I attended the deceased from Aug 13, 1944 to Aug 14, 1944 that I last saw him alive on Aug 14, 1944 and that death occurred on the date stated above at 1 P. M.
 Immediate cause of death _____ DURATION _____
Cholerae Infantum
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operation 120A
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? In or about home, on farm, in industrial plant, in public place?
(Specify type of place)
 While at work? _____ (a) Nature of injury _____

23. Signature D. C. Deason
(M. D. or other)
 Address Owingsville Date signed Aug 19, 1944