

COMMONWEALTH OF KENTUCKY

State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3051

1 PLACE OF DEATH

County 7302

Vol. 2027

Ino. Town Salt Lick

City \_\_\_\_\_

Registration District No. 1-2

Primary Registration District No. 4248

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

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

2 FULL NAME Hannah B. Baldy

(a) Residence No. Salt Lick, Ky. St. \_\_\_\_\_ Ward \_\_\_\_\_

Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married Widowed or Divorced Single (Write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_

6 DATE OF BIRTH August 10 86 (Month) (Day) (Year)

7 AGE 69 yrs 6 mos 1 da. If less than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housework (b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (city or town) (State or country) W. T. Tuckey

PARENTS 10 NAME OF FATHER Jeff Baldy 11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky 12 MAIDEN NAME OF MOTHER Barbara Ann Kind 13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 (Informant) John Baldy (Address) Salt Lick, Ky.

15 Filed 2-12-35 - Mr. S. C. Alvord Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 11 35 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1/34 19\_\_\_\_ to Feb. 9/35 19\_\_\_\_ that I last saw her alive on about Jan. 16/35 19\_\_\_\_ and that death occurred on the date stated above at 9:00 A. The CAUSE OF DEATH\* was as follows:

Organic Heart Disease several years

(Duration) several years yrs. mos. ds.

Contributory Cardiac Drépsy (Secondary)

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

18 WHERE WAS DISEASE CONTRACTED If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? NO

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Dr. C. A. Jones M. D. Feb. 12, 1935 (Address) Salt Lick, Ky.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Gene's Cemetery DATE OF BURIAL Feb 12 35

20 UNDERTAKEN Barnes & Harrison ADDRESS Salt Lick, Ky.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
M. D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language so that it may be properly classified. Certificates are very important. See instructions on certificate.