

Community of **Kentucky**  
 STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
**CERTIFICATE OF DEATH**

File No. **17489**

1 PLACE OF DEATH

County **Bath**

Vot. Prec. **ST. 4**

Inc. Town

City (No. St., Ward)

Registration District No.

Primary Registration District No. **12**

Registered No.

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

2 FULL NAME **Eva A. Sallis**

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **married**  
(Write the word)

6 DATE OF BIRTH **1**  
(Month) (Day) (Year)

7 AGE **22** yrs. **2** mos. **2** ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) **Bath Co Ky**

10 NAME OF FATHER **Rhedora Thomasburg**

11 BIRTHPLACE OF FATHER (State or country) **Bath Co Ky**

12 MAIDEN NAME OF MOTHER **Kate Thomas**

13 BIRTHPLACE OF MOTHER (State or country) **Ky**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Alford Goldy**

(Address) **Salt Lick, Ky**

15 Filed **6-14-1919** **M. H. Alexander**  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH **June 13, 1919**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **Feb 4, 1919**, to **Apr 15, 1919**, that I last saw him alive on **Apr 15, 1919**, and that death occurred on the date stated above at **8 P.m.** The CAUSE OF DEATH\* was as follows:

**Tuberculosis of the Lungs**

(Duration) ... yrs. **5** mos. **5** ds.

Contributory **Influenza**  
(SECONDARY) (Duration) ... yrs. **1** mos. **1** ds.

(Signed) **C. D. Jones**  
**June 18, 1919** (Address) **Salt Lick, Ky.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MANNER 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 **Lower Synonity** DATE OF BURIAL **June 14, 1919**

20 UNDERTAKER **Mrs. J. W. Vaughan** ADDRESS **Salt Lick**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 M. 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. Exact statement of OCCUPATION is very important. See instructions on back of certificate.