

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

23638

1. PLACE OF DEATH
County Bath
Vol. Fol. _____
Ind. Town _____
City _____

Registration District No. 672
Primary Registration District No. 182

File No. _____
Registered No. _____

2. FULL NAME George William Day
(If death occurred in a hospital or institution, give its NAME instead of street and number)
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed or Divorced (write the word) Married
6. DATE OF BIRTH May 17 1891
7. AGE Years 54 Months 5 Days 12 If LESS than 1 yr. _____ mo. _____ ds.
8. Trade, profession, or particular kind of work done, or occupation, occupation, occupation, etc. farmer
9. Industry or business in which work was done, as with mill, merchant, bank, etc.
10. This deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH
22. DATE OF DEATH October 31 1935
23. I HEREBY CERTIFY that I attended deceased from about Aug. 15 to Oct 19 1935
I last saw him live on Oct 19 1935; death is said to have occurred on the date stated above, at _____ in _____
The principal cause of death and related causes of importance in order of onset were as follows:
Tuberculosis of bronchial tubes Date of onset _____
Contributory causes of importance not related to principal cause: Drugs Stomach

12. BIRTHPLACE Kentucky
FATHER
13. NAME William Marion Day
14. BIRTHPLACE Kentucky
MOTHER
15. MAIDEN NAME Anna May Utterback
16. BIRTHPLACE Kentucky
17. INFORMANT Mrs. Maude Day
(Address) East Lick, Ky
18. BURIAL CREMATION, OR REMOVAL
Place Jones Cem Date October 31 1935
19. UNDERTAKER Barnes & Harshman
(Address) East Lick, Ky
20. FILED Oct 30 1935 - W. B. Alexander

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ date of injury _____
Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____
(Signed) Dr. C. J. Jones M. D.
(Address) East Lick, Ky

MARGIN RESERVED FOR BINDING

10. B. WRITE PLAINLY, WITH AFFIXING 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. See instructions on back of certificate.