

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

File No. **22673**

1 PLACE OF DEATH

County Bath

Vol. No. 4035

Inn. Town _____

City _____

Registration District No. 52

Primary Registration District No. 4085

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

Registered No. _____

2 FULL NAME Artisha McEllohan

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonvalident, 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 Female 4 COLOR OR RACE White 5 Single Married Widowed Divorced
(Write the word)

5a If married, widowed, or divorced HUSBAND of William Gallahan (or) WIFE of _____

6 DATE OF BIRTH July 29/1888
(Month) (Day) (Year)

7 AGE 44 yrs. 2 mos. 5 ds. IF LESS THAN 1 day _____ hrs. or _____ min?

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housekeeper in own home (b) General nature of industry, business or establishment in which employed (or employer) _____

9 BIRTHPLACE (city or town) Bath Co., Ky. (State or country)

PARENTS
10 NAME OF FATHER Joseph S. Stoll
11 BIRTHPLACE OF FATHER (city or town) Bath Co., Ky. (State or country)
12 MAIDEN NAME OF MOTHER Francis McCarty
13 BIRTHPLACE OF MOTHER (city or town) Bath Co., Ky. (State or country)

14 (Informant) D. C. Jones
(Address) Salt Lick Ky.

15 Filed 10-5-32 W. C. Alexander
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 4/32
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 29/31, 1931, to Sept. 30/32, 1932, that I last saw her alive on May 23/32, 1932, and that death occurred on the date stated above at 12:30 AM

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus

(Duration) probably 7 yrs. ds.

Contributory (Secondary) _____ (Duration) _____ yrs. mos. ds.

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

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? (Signed) D. C. Jones, M. D.
Oct. 4/32 1932 (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 Jones Cemetery DATE OF BURIAL Oct 5 1932

UNDERTAKER Barnes-Horsman ADDRESS Salt Lick Ky.

REMARKS RESERVED FOR RECORDS

WRITE PLAINLY, IN 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. Exact statement of OCCUPATION is very important. See instructions on back of certificate.