

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11583

PLACE OF DEATH

County Bath

Vet. No. 5-105-

Ino. Town

City

Registration District No. 5-2

Primary Registration District No. 5-106

(No. St., Ward)

File No.

Registered No.

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

FULL NAME Flossie Lee Myers

MARGIN RESERVED FOR RECORDS

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANY RECORD
Every item of information should be carefully supplied. ASE should, 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.

PERSONAL AND STATISTICAL PARTICULARS

1 SEX Female 2 COLOR OR RACE White 3 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

4 DATE OF BIRTH Jan 18 1893
(Month) (Day) (Year)

7 AGE 22 yrs. 4 mos. 7 ds. IF LESS than 1 day... hrs. or... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Ky

10 NAME OF FATHER Edward Myers

11 BIRTHPLACE OF FATHER (State or country) Ky

12 MAIDEN NAME OF MOTHER Abigail B. Roberts

13 BIRTHPLACE OF MOTHER (State or country) Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Myers

(Address) Salt Lick, Ky

15 Filed 26 1915 by James C. Williams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 10, 1903, to Jan 31, 1915, that I last saw him alive on May 10, 1915, and that death occurred on the date stated above at 8 a.m. The CAUSE OF DEATH was as follows: Subarachnoid of the Brain

(Duration) 12 yrs. mos. ds.

Contributory (Secondary) Diarrhea

(Duration) yrs. mos. ds.

(Signed) L. F. Robbins, M. D.
May 25, 1915 (Address) Salt Lick, Ky

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR REGENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL ON REMOVAL Jones Cemetery

20 UNDERTAKER Ms. Williams

DATE OF BURIAL 5 26 1915

ADDRESS Salt Lick