

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated in full. ACTUALLY, 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.

Form V, S. 1-50m-10-25-25

## COMMONWEALTH OF KENTUCKY

 State Board of Health  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

1 PLACE OF DEATH

County RowanVot. Pct. the Farmers No 11Inc. Town Farmer

City

Registration District No. 180Primary Registration District No. 2586(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)File No. 12607Registered No. 132 FULL NAME Bella Jean Hogg

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

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 female4 COLOR OR RACE white5 Single \_\_\_\_\_ Married \_\_\_\_\_  
Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
(Write the word)

6a If married, widowed, or divorced

HUSBAND of  
(or) WIFE of \_\_\_\_\_6 DATE OF BIRTH May 1 1933

(Month) (Day) (Year)

7 AGE six born

yrs. mos. ds.

IF LESS than 1  
day \_\_\_\_\_ hrs  
or \_\_\_\_\_ min?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business or establishment in which employed (or employer) \_\_\_\_\_9 BIRTHPLACE (city or town) Farmer, Ky  
(State or country)

PARENTS

10 NAME OF FATHER Edman Hogg11 BIRTHPLACE OF FATHER (city or town) Rowan Co. Ky  
(State or country)12 MAIDEN NAME OF MOTHER Lillian Gladys Jones13 BIRTHPLACE OF MOTHER (city or town) Barth Co. Ky  
(State or country)

14

(Informant) Dr. C. J. Jones  
(Address) Salt Lick, Ky

15

Filed May 2, 1933 Mrs I. A. E. Evans  
Registrar

## MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH May 1 1933  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 1 1933 to May 1 1933that I last saw him alive on May 1 1933

and that death occurred on the date stated above

The CAUSE OF DEATH\* was as follows:

Still born probably due to premature rupture of placental sac. skin thick  
(Duration) \_\_\_\_\_ yrs. mos. ds. 12 hrs

Contributory

(Secondary) 4/15

(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) Dr. C. J. Jones M. D.(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 DATE OF BURIAL

Jones Cemetery May 2, 1933

UNDERTAKER

Ramich

ADDRESS