

1 PLACE OF DEATH

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

22677

County Bath

Vot. Pct. 4085

Registration District No. 57

File No. \_\_\_\_\_

Ino. Town \_\_\_\_\_

Primary Registration District No. 4295

Registered No. \_\_\_\_\_

City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Earl Miller

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single Married Widowed or Divorced single  
(Write the word)

5a If married, widowed, or divorced HUSBAND of \_\_\_\_\_ (or) WIFE of XXXXXX

6 DATE OF BIRTH Oct. 8/32  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day \_\_\_\_\_ hrs or \_\_\_\_\_ min?

8 OCCUPATION OF DECEASED  
(a) Trade, profession or particular kind of work XXXXXX  
(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 Edward Leonard Miller  
11 BIRTHPLACE OF FATHER (city or town) W. Va.  
(State or country)  
12 MAIDEN NAME OF MOTHER Irene Lee Warner  
13 BIRTHPLACE OF MOTHER (city or town) Bath Co., Ky.  
(State or country)

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

15 Filed 10-9-32 Dr. S. L. Hyman  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 8/32  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8/32, 1932, to Oct. 8/32, 1932 that I last saw him alive on Oct. 8/32, 1932 and that death occurred on the date stated above at 1 P. m. The CAUSE OF DEATH\* was as follows:  
I found the Foreman Ovale failed to close completely

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. 21/32 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 10-9-32  
UNDERTAKER none ADDRESS none

WRITE PLAINLY IN UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information be carefully supplied. AGE should be stated. 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.