FORM V. S. 1-100 M-1-10-11.

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

1 PLACE OF DEATH
County Rowan
Vot. Pct. #2 Farmers
Inc. Town Farmers
City ..... (No. ..... St. ..... Ward)

Registration District No. 7492
Primary Registration Dist. No. 7492

File No. 2788
Registered No. 2
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs Eliza Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH June (Month) 16 (Day), 1830 (Year)

7 AGE 82 — 6 — 19
85 yrs. 6 mos. 5 ds.
If LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kentucky

PARENTS
10 NAME OF FATHER Jack Cassity
11 BIRTHPLACE OF FATHER (State or country) Kentucky
12 MAIDEN NAME OF MOTHER Margaret Richards
13 BIRTHPLACE OF MOTHER (State or country) Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. E. Craig
(Address) Farmers Ky

15 Filed Jan 6, 1913 H. D. Myers
REGISTRAR

11—8104

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 5 (Day), 1913 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h— alive on ....., 191...,
and that death occured, on the date stated above, at 3 P.m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Sudent (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. Thos. A. Evans, M.D.
Jan 6, 1913, (Address) Farmers

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS of INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

(18) LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Jones Cemetery
DATE OF BURIAL 1 — 7 —, 1913
20 UNDERTAKER A. L. Green
ADDRESS Farmers Ky

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
R. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state NAME OF DEATH in plain [illegible], so that it may be properly classified. Any [illegible] statement of OCCUPATIONS is very important. See instructions at back of certificate.