

M. B.—Every item of information should be carefully supplied. AGE should be stated in full. 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. B. 1-200 M. 10-10-10

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

1 PLACE OF DEATH
County Rowan
Vot. Pot. # 2
Inc. Town
City Cathart (No. Stewart)
2 FULL NAME

File No. 30593
Registered No. 29
(If death occurred in a hospital or institution, give its NAME, instead of street and number.)

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 Not known
(Month) (Day) (Year)

7 AGE 40
yrs. mos. ds.
If LESS than 1 day, ____ hrs., ____ min.

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

9 BIRTHPLACE (State or country) Ellis

10 NAME OF FATHER Louis Sigall
11 BIRTHPLACE OF FATHER (State or country) Not known
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Sigall & Jim Fuller
(Address) Barrow Ky.

15 Filed Nov 11, 1913 Made by Myers
REGISTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 11, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from 1913 to 1913,
that I last saw her alive on Oct 1st, 1913,
and that death occurred, on the date stated above, at P.M.,
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
(Duration) 1 yrs. 9 mos. ds.

Contributory (Secondary) (Duration) Yes yrs. 9 mos. ds.
(Signed) Allen W. D. Jones, M. D.
11/10/1913 (Address) Barrow Ky.

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MECHANISM OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
(16) 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 Funerary
20 UNDERTAKER Richard Sugrue
DATE OF BURIAL Nov 11, 1913
ADDRESS Barrow