

## 1 PLACE OF DEATH

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

18654

File No. ....

Registered No. ....

County BathVol. No. 4085Registration District No. 62

Inc. Town .....

Primary Registration District No. ....

City .....

(No. .... St., .... Ward)

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

2 FULL NAME Mary Magdalene Williams(a) Residence. No. Salt Lick, Ky. St., .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)

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 female 4 COLOR OR RACE negro 5 Single Married Widowed or Divorced single  
(Write the word)6a If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of xxxxxxx6 DATE OF BIRTH April 12 1930  
(Month) (Day) (Year)7 AGE 3 yrs. 22 mos. 22 ds. IF LESS than 1 day.....hrs. or.....min?

## 8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. xxxxxxx

(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 George Henry Williams11 BIRTHPLACE OF FATHER (city or town) S. Carolina  
(State or country)12 MAIDEN NAME OF MOTHER Clorine Ficklen13 BIRTHPLACE OF MOTHER (city or town) Salt Lick, Ky.  
(State or country)14 (Informant) J. H. Williams  
(Address) Salt Lick, Ky.15 Filed 8/3, 1930 Mr. S. C. Alexander  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 3/30 1930  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased  
from Aug. 3/30, 1930, to Aug. 3/30, 1930,  
that I last saw him alive on Aug. 3/30, 1930,  
and that death occurred on the date stated above at 2:00 p.m.  
The CAUSE OF DEATH\* was as follows:Mal Nourishment(Duration) 3 yrs. 3 mos. 3 ds.Contributory  
(Secondary)(Duration) 3 yrs. 3 mos. 3 ds.

## 18 WHERE WAS DISEASE CONTRACTED

If not at place of death? xxxxDid an operation precede death? no Date of .....Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) D. C. Jones M. D.Aug. 3, 1930 (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 8-4, 1930

20 UNDERTAKER

ADDRESS