

Commonwealth of Kentucky
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12938

1 PLACE OF DEATH
County Bath
Vol. No. 5106
Inc. Town 20
City Ma

Register District No. 32
Primary Registration District No. 5106

File No. _____
Registered No. _____
(If death occurred in a hospital or institution, give the name of the hospital and number.)

2 FULL NAME Red Turner

PERSONAL AND STATISTICAL PARTICULARS

1 SEX <u>male</u>	2 COLOR OR RACE <u>negro</u>	3 SINGLE, MARRIED, WIDOWED, OR SEPARATED <u>single</u>
4 DATE OF BIRTH <u>Apr 14, 1902</u>		
7 AGE <u>15</u> yrs. <u>1</u> mo. <u>29</u> da. <small>(If less than 1 day, give hrs. or min.)</small>		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Bath Co., Ky.</u>		
10 PARENTS	11 NAME OF FATHER <u>Clifford Turner</u>	
	12 BIRTHPLACE OF FATHER (State or country) <u>Ky.</u>	
	13 MAIDEN NAME OF MOTHER <u>Edith Pagon</u>	
	14 BIRTHPLACE OF MOTHER (State or country) <u>Ky.</u>	

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH
May 4, 1917

16 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1917, to May 1, 1917, that I last saw him alive on May 1, 1917, and that death occurred on the date stated above at 20. The CAUSE OF DEATH* was as follows:
Tuberculosis of Lung

Contributory (Secondary) _____ (Describe) _____ yrs. _____ mo. _____ da.

(Name) C. D. Jones M. D.
May 4, 1917 (Address) Salt Lick, Ky.

*Specify Disease Causing Death, or, in death from Trauma, Give more than (1) Cause of Injury and (2) Whether Alimentary, Bronchial, or Nervous.

17 LENGTH OF RESIDENCE (For Hospital, Institution, Year, Month or Recent Residence)
At place of death _____ yrs. _____ mo. _____ da. State _____ yrs. _____ mo. _____ da.

Where was disease contracted, if not at place of death? _____ Former or social residence _____

18 PLACE OF BURIAL OR REMOVAL
Jones graveyard

19 UNDERTAKER _____ ADDRESS _____

DATE OF BURIAL 5-6-17

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. C. D. Jones
(Address) Salt Lick, Ky.
Filed May 4, 1917 S. L. Alexander
Registrar

REWRITE IN PLAIN, WITH NECESSARY CORRECTIONS. THIS IS A PERMANENT RECORD. Every item of information should be carefully checked. AGE should be stated EXACTLY. PARTICULARS should be stated EXACTLY. If possible, state the date of birth. Exact statement of DEATH should be given. If death occurred in a hospital or institution, give the name of the hospital and number. INSTRUCTIONS on back of certificate.