

MARCH RESERVED FOR BURIAL

O—**WRITE PLAINLY WITH U.** **DRUGS INC.—THIS IS A PERMANENT RECORD.** Every item of information should be carefully repeated. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I. PLACE OF DEATH:		II. USUAL RESIDENCE OF DECEDENT:	
(a) County	<u>Macon Co.</u>	(a) State	<u>Perry County</u>
(b) City or town	<u>Frenchburg, Rural</u>	(b) County	<u>Frenchburg, Ky.</u>
(c) Name of hospital or institution	(III outside city or town limits, write BUREAU)		
<u>Garrison Hospital, No. 40 - 1 1/2 mi. S.E.</u>		(III outside city or town limits with street number or location)	
(II) not in hospital or institution with street number or location)		(IV) months or days)	
(VI) Length of stay in hospital or community		3 years	
III. FULL NAME: <u>Mary Moore Igo</u>			
(b) If veteran		(b) Social Security	
Name war	no	Name no	no
4. Sex: <u>Female</u> 5. Color of hair: <u>white</u>		6. Single, widowed, married, divorced: <u>married</u>	
7. Name of husband or wife: <u>Clay Igo</u>			
8. Age of husband or wife (if alive): <u>76</u>			
9. Birth date of deceased: <u>December 11, 1900</u>			
10. A.D.E.: Years <u>78</u>		Months <u>7</u>	Days <u>4</u>
11. Residence: <u>Macon County</u>			
12. Usual occupation: <u>Housewife</u>			
13. Industry or business: <u>Cook House</u>			
14. Name: <u>Henry Moore</u>			
15. Relationship: <u>Sister</u>			
16. Maiden name: <u>Belle Hughes</u>			
17. Relationship: <u>Sister</u>			
18(a) Informant's own relation: <u>Mrs. Morrison</u>			
18(b) Address: <u>Frenchburg, Ky.</u>			
19. BURIAL, Cremation, OR REBURNAL: Burial in woodland Date: <u>July 16, 1939</u>			
20. Signature of funeral director: <u>Albert Morrison</u>			
21. Address: <u>Frenchburg, Ky.</u>			
22(a) Date signed by local registrar: <u>July 15, 1939</u> (b) Name of registrar: <u>Alene Farrell</u>			
23. Date signed by local registrar: <u>July 15, 1939</u> (b) Name of registrar: <u>Alene Farrell</u>			
24. Address: _____ Date signed: _____			
MEDICAL CERTIFICATION			
15. DATE OF DEATH: <u>July 15</u>		16. I hereby certify that I attended the deceased from <u>July 12</u> to <u>July 15</u> , that I last saw him alive at <u>July 12</u> at <u>7</u> and that death occurred on the date above: <u>July 15</u> 1939	
17. Immediate cause of death: <u>Convulsions</u>			
18. DURATION			
19. Cause: <u>Epileptic condition</u>			
20. Other conditions (Include pregnancy within 3 months of death):			
Major findings:			
21. Of convulsions: <u>none performed</u>			
22. Of epilepsy: <u>none performed</u>			
23. If death was due to external cause, fill in the following:			
24. Accidental, suicide, or homicide (specify): _____			
25. Date of occurrence: _____			
26. Where did injury occur? Is it at about home, on farm, in industrial place, in public place? _____ (Specify type of place)			
27. Where at work? _____ (a) Means of injury: _____			
28. Signature: <u>A. T. Belley</u> (M. D. or other) Date signed: <u>July 17, 1939</u>			