28980

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

File No. .....

Registration District No. 7-2

Primary Registration Dist. No. 4285

Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County Bath

Vot. Pct. .....

Inc. Town .....

City Salt Lick Ky (No. ..... St. ..... Ward)

1 FULL NAME Francis Lyon

PERSONAL AND STATISTICAL PARTICULARS

2 SEX: Female

3 COLOR OR RACE: W

4 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

5 DATE OF BIRTH: Feb 1 (Month) (Day) (Year)

7 AGE: 43 about yrs. ..... mos. ..... ds. [If LESS than 1 day ..... hrs. or ..... min.]

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

9 BIRTHPLACE (State or country): Menifee Co Ky

PARENTS

10 NAME OF FATHER: Wm. Smith

11 BIRTHPLACE OF FATHER (State or country): Ky

12 MAIDEN NAME OF MOTHER: Dora Smith

13 BIRTHPLACE OF MOTHER (State or country): Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Lyon
(Address) Salt Lick Ky

15 Filed 12-7 1930 Mrs H. Alyan (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 6 (Month) (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1930 to Nov 20 1930 that I last saw him alive on Nov 20 1930 and that death occured, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Acute Regurgitation of Heart

Duration 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) General Dropsy

Duration ..... yrs. 6 mos. ..... ds.

(Signed) J. C. Alexander M. D.

Dec 12 1930 (Address) Salt Lick Ky

*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: 12-7 1930

20 UNDERTAKER: None

ADDRESS: —

11—6200

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B. B.—Every line of information should be carefully supplied. ARE should be checked. CAREFULLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. The statement of OCCUPATIONS is very important. See instructions on back of certificate.