

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

File No. **84**
Registered No. _____

1 PLACE OF DEATH
County **Bath**
Vol. No. _____ Registration District No. **52**
Loc. Town _____ Primary Registration District No. **4285**
City _____ (No. _____ St. _____ Ward _____)
(If death occurred in a hospital or institution, give the NAME (instead of street and number))

2 FULL NAME **Madeline Snelling**
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident, give city or town and State)
New long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
1 SEX **Female** 4 COLOR OR RACE **White** 5 MARRIAGE STATUS **Single**
(Write the word)
6a **Married**, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____
7 DATE OF BIRTH **May 26 1924**
(Month) (Day) (Year)
8 AGE **1 yrs. 7 mos. 23 ds.**
if less than 1 yr. say mos. ds.
9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business, or establishment in which employed (or employer) _____

10 BIRTHPLACE (city or town) (State or country) **Kentucky**
PARENTS
11 NAME OF FATHER **Jimalee Snelling**
12 BIRTHPLACE OF FATHER (city or town) (State or country) **Kentucky**
13 MAIDEN NAME OF MOTHER **Thelma Harris**
14 BIRTHPLACE OF MOTHER (city or town) (State or country) **Kentucky**

15 (Informant) **Jimalee Snelling**
(Address) **Bath, Wick Co., Ky.**
16 Filed **1-20-34** by **Mrs. J. C. Reynolds**
Registrar

MEDICAL CERTIFICATE OF DEATH
17 DATE OF DEATH **January 18 1934**
(Day) (Month) (Year)
18 I HEREBY CERTIFY, That I attended deceased from **Jan 12, 1934** to **Jan 18, 1934**
that I last saw h. **alive** on **Jan 15, 1934**
and that death occurred on the date stated above at **h. m.**
The CAUSE OF DEATH* was as follows:
Pneumonia Fever
9-10-6
(Duration) _____ yrs. mos. ds.
Contributory (Secondary) **Whooping Cough**
(Duration) _____ yrs. mos. ds.
19 WHERE WAS DISEASE CONTRACTED
If not at place of death? _____
Did an operation precede death? **no** Date of _____
Was there an autopsy? **no**
What test confirmed diagnosis?
(Signed) **J. C. Dabson** M. D.
Jan 20, 1934 (Address) **Bainbridge, Ky.**
*State the Disease Causing Death, or, if death from Violent Cause, state (1) Means and nature of injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL OR REMOVAL **Jones Cemetery**
DATE OF BURIAL **Jan 19 1934**
21 UNDERTAKER **Barnes + Harman**
ADDRESS **Bath, Wick Co., Ky.**

WRITE PLAIN WITH UNFADING INK—THIS IS A PERMANENT RECORD
NEVER REWRITED FOR ERRORS
N. B.—Every item of information should be carefully supplied. AGE* should be stated in plain figures, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.