Form V. S. 1—50m—10-29-25

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

7872

File No.

Registered No.

1 PLACE OF DEATH

County Bath

Vot. Pct. 4085 Registration District No. 62

Inc. Town Primary Registration District No. 4085

City (No. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Shirley Staton

(a) Residence. No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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 white

5 Single, Married, Widowed or Divorced (Write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH Nov. 9/1908 (Month) (Day) (Year)

7 AGE 23 yrs. 5 mos. 10 ds. If LESS than 1 day, ... hrs or ...... min?

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work domestic
(b) General nature of industry, business or establishment in which employed (or employer)

9 BIRTHPLACE (city or town) (State or country) Bath Co., Ky.

PARENTS

10 NAME OF FATHER William Harrison Staton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Meniffee Co., Ky.

12 MAIDEN NAME OF MOTHER Mary Caldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rowan Co., Ky.

14 (Informant) W. H. Staton

(Address) Salt Lick, Ky.

15 Filed 4-20, 1932 W. H. Alexander Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 19/32 (Month) (Day), 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 17/32, 19......, to Apr. 17/32, 19......,

that I last saw her alive on April 17/32, 19......,

and that death occurred on the date stated above at 3:30 P

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis and ~~Tuberculosis~~
Tuberculosis of Larynx 2-3

(Duration) ...... yrs. 4 mos. ...... ds.

Contributory (Secondary)

(Duration) ...... yrs. ...... mos. ...... ds.

18 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) Dr. C. D. Jones, M. D.

Apr. 19 1932 (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	April 21, 1932
UNDERTAKER	**ADDRESS**
Barnes & Horseman	Salt Lick, Ky

MARGIN RESERVED FOR BINDING

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

N. B.—Every item of information should be carefully supplied. AGE 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. See instructions on back of certificate.