FORM F 4 1-60M 2-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

24590

File No. .....

Registered No. .....

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

1 PLACE OF DEATH

County Laurel

Vot. Pct. Newcomb Registration District No. 1521

Inc. Town ..... Primary Registration District No. .....

City ..... (No. ..... St., ... Ward)

2 FULL NAME Sarah Elizabeth Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: W

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

6 DATE OF BIRTH: June 23, 1856 (Month) (Day) (Year)

7 AGE: 65 yrs. 2 mos. 6 ds. [IF LESS than 1 day, hrs. or min.?]

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

9 BIRTHPLACE (State or country): Laurel Co, Ky

PARENTS

10 NAME OF FATHER: Alex Bolton

11 BIRTHPLACE OF FATHER (State or country): Laurel Co, Ky

12 MAIDEN NAME OF MOTHER: Delia Stevenson

13 BIRTHPLACE OF MOTHER (State or country): Whitley Co, Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charity Poynter

(Address) Bald Rock Ky

15

Filed ..... 19 ..... Registrar

11—31M

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 1 (Month) 1 (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 1, 1921, that I last saw h.. alive on Sept 1, 1921, and that death occurred on the date stated above at ..... m. The CAUSE OF DEATH* was as follows:

Chronic Infectious Enteritis

(Duration) ..... yrs. 8 mos. ..... ds.

Contributory (Secondary) Critical Urinary Fever

(Duration) ..... yrs. 8 mos. ..... ds.

(Signed) J. G. Johnson, M. D.

Sept 2, 1921 (Address) London Ky R.R. #1

*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: Kingston Grave yard

DATE OF BURIAL: Sept 3, 1921

20 UNDERTAKER: K. L. Skaggs

ADDRESS: London Ky

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

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated in exact terms, as that it may be properly classified. EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.