

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

5949

1 PLACE OF DEATH

County Muhlenberg

File No. \_\_\_\_\_

Vol. Pct. \_\_\_\_\_

Registration District No. 1087Registered No. 7

Inc. Town \_\_\_\_\_

Primary Registration District No. 2435City Central City

(No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

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

2 FULL NAME

Dorothy Campbell Fentress

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Single  
Married  
Widowed  
or Divorced  
(Write the word)

6 DATE OF BIRTH Oct 20 1916  
(Month) (Day) (Year)

7 AGE 6 yrs. 5 mos. 24 ds.  
IF LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

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

9 BIRTHPLACE (State or country) Ky

PARENTS  
10 NAME OF FATHER J. Lee Fentress  
11 BIRTHPLACE OF FATHER (State or country) Ky  
12 MAIDEN NAME OF MOTHER Jennie L. Offutt  
13 BIRTHPLACE OF MOTHER (State or country) Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Lee Fentress(Address) Central City Ky

15 Filed 7/30 1923 at Central City

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 14 1923  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-12-1923 to 2-14-1923, that I last saw her alive on 2-12-1923, and that death occurred on the date stated above at 8 P.M.

The CAUSE OF DEATH\* was as follows:

Accidental  
(Duration) 4000 hours yrs. mos. ds.

Contributory (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. mos. ds.

(Signed) Ch. H. ... M. D.  
2-14-1923 (Address) Central City 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. d.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Fairmount DATE OF BURIAL 2/15/23

20 UNDERTAKER Moore and Co. ADDRESS Central City