

## PLACE OF DEATH

STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty *Muhlenberg*

File No. ....

Vet. Post *Hillside*Registration District No. *xxx 7136*

Registered No. ....

Inq. Town ..... Primary Registration District No. ....

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

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

FULL NAME *Archie W. Oates*

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

|                      |                                 |   |
|----------------------|---------------------------------|---|
| 3 SEX<br><i>Male</i> | 4 COLOR OR RACE<br><i>White</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word)<br><i>Married</i> |
|----------------------|---------------------------------|---|

|                                      |
|--------------------------------------|
| 16 DATE OF DEATH<br><i>5-18-1922</i> |
| (Month) (Day) (Year)                 |

|  |
|--|
| 6 DATE OF BIRTH<br><i>Sept 9, 1873</i> |
| (Month) (Day) (Year)                   |

17 I HEREBY CERTIFY, That I attended deceased *never attended prior before.*  
from *never attended prior before.*, 191....., to....., 191.....,  
that I last saw him alive on *5-18*....., 192.....  
and that death occurred on the date stated above  
at *3 P.m.* The CAUSE OF DEATH\* was as follows:

|                                    |  |
|------------------------------------|--|
| 7 AGE<br><i>48 yrs 8 mos 9 ds.</i> | IF LESS than<br>1 day... hrs.<br>or... min.? |
|------------------------------------|--|

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

*Pulmonary Tuberculosis*  
.....(Duration).... yrs..... mos..... ds.

9 BIRTHPLACE  
(State or country)  
*Muhlenberg Co Ky*

Contributory *Pulmonary Haemorrhage*  
(SECONDARY)  
.....(Duration).... yrs..... mos.. 2 ds.  
(Signed) *W. C. W. Neil*, M. D.  
*5-18*....., 1922 (Address) *Central City Ky*

10 NAME OF FATHER  
*Archie Oates*

11 BIRTHPLACE OF FATHER  
(State or country)  
*Muh. Co. Ky*

12 MAIDEN NAME OF MOTHER  
*Ma Rodgers*

13 BIRTHPLACE OF MOTHER  
(State or country)  
*West Va*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *J. M. Oates*  
*Hillside Ky*  
(Address) .....

\*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. State.... yrs..... mos..... ds.  
Where was disease contracted, if not at place of death? .....

15 REGISTRAR  
*5/19/22*  
*W. C. W. Neil*  
*Muhlenberg Co Ky*

|   |                                       |
|---|---------------------------------------|
| 19 PLACE OF BURIAL OR REMOVAL<br><i>Withers B. S.</i> | DATE OF BURIAL<br><i>May 19, 1922</i> |
| 20 UNDERTAKER<br><i>McDonald &amp; Hewitt</i>         | ADDRESS<br><i>Greenville Ky</i>       |

N. B.—Every item of information on this certificate 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.