FORM V. S. 1-500M 2-29-12

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

#12

File No. 5786

Registered No. 6

1 PLACE OF DEATH

County: Adair

Vot. Pct.: Dry Creek Registration District No. 5012

Inc. Town: ..... Primary Registration District No. 12

City: Dry Creek No. ..... St., ... Ward)

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

2 FULL NAME: Rhoda Raimondo

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Dont Know (Month) (Day), 1 (Year)

7 AGE: Dont 57 yrs. ..... mos. ..... ds.

IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Ky

PARENTS

10 NAME OF FATHER: Dan Brown

11 BIRTHPLACE OF FATHER (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Thomas Rice

(Address): Fairview Ky

Filed 3-6, 1915 C. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Mch 5, 191[illegible] (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191...., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred on the date stated above at 7 a.m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(1)

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

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

(Signed) J. C. Gore, M. D.

Mch 6, 1915 (Address) Knifley 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. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Dorsey Cemetery

DATE OF BURIAL: Mch 6, 1915

20 UNDERTAKER: Elmer Dixon

ADDRESS: Parrow 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 EXACTLY. PHYSICIANS 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.

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