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

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Hopkins

Vot. Pct. No. 6

Registration District No. 531

File No. 13051

Registered No. 241

Inc. Town

Primary Registration District No. 2266

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

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

2 FULL NAME Mary Ellen Rammater

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct (Month) 20 (Day), 1913 (Year)

7 AGE: ..... yrs. 6 mos. 20 ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Earlington Ky

PARENTS

10 NAME OF FATHER: Jack Rammater

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

12 MAIDEN NAME OF MOTHER: Isabel Smith

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Rammater

(Address) Earlington Ky

15 Filed 5-11, 1914 E. M. Bohern, E. Stokes, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 10 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1914, to May 10, 1914, that I last saw her alive on May 10, 1914, and that death occurred on the date stated above at 9 P.m. The CAUSE OF DEATH* was as follows:

F. B. Meningitis

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

Contributory (SECONDARY) .....

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

(Signed) W. P. Ross, M. D.

5/10, 1914 (Address) Earlington 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: Oakwood Cemetery

DATE OF BURIAL: 5-11, 1914

20 UNDERTAKER: St Bernard M. Co

ADDRESS: Earlington

11—3184

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.

#1948