FORM V. S. [illegible]

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Washington

Vot. Pct. M[illegible]ville No 2

7772

File No. 2983

Inc. Town ....

Registered No. 27

City .... (No. .... St.) .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Susan A. Stiles

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX: Female	4 COLOR OR RACE: White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): widowed
6 DATE OF BIRTH: May (Month) 2 (Day) 1829 (Year)		
7 AGE: 83 yrs. 8 mos. 17 ds.	If LESS than 1 day .. hrs. or .. min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work: Had none. lived (b) General nature of industry business, or establishment in which employed (or employer): with her daughter		
9 BIRTHPLACE (state or country): Wash Co Ky		
PARENTS	10 NAME OF FATHER: Benjamin Pile	
	11 BIRTHPLACE OF FATHER (State or country): Washington Co Ky	
	12 MAIDEN NAME OF MOTHER: Rhoda Weathers	
	13 BIRTHPLACE OF MOTHER (State or country): Nelson Co Ky	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lydia H. Shehan

(Address) Maud Ky

15

Filed Jan 17th 1913 E. E. Wakefield, Registrar

11—8184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jany (Month) 16 (Day), 1913 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov ...., 1912, to Jany 16 ...., 1913, that I last saw her alive on Jany 16 ...., 1913, and that death occured, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Had a fractured Hip by from by falling down Stairs and death resulted from same. Never was able to move (Duration) .... yrs. 2 mos. 15 ds.

Contributory (SECONDARY) .... (Duration) .... yrs. .... mos. .... ds.

(Signed) [illegible] Shehan, M.D.

Jany 17, 1913 (Address) Maud 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: Beech Fork Cemetery

DATE OF BURIAL: Jany 17 1913

20 UNDERTAKER: Clyde [illegible]

ADDRESS: Springfield

[Left margin:] 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.

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