

DEPARTMENT OF HEALTH OF KENTUCKY
State Board of Health
DEPARTMENT OF VITAL STATISTICS
CERTIFICATE OF DEATH

2160

1 PLACE OF DEATH

County Madison

File No. _____

Vot. Prec. W. R. R. Ry. Registration District No. 1067

Registered No. 1

Loc. Town _____ Primary Registration District No. 12

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

2 FULL NAME Elisha A. Wood

(a) Residence. No. _____ St., _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH Nov-18 1884
(Month) (Day) (Year)

7 AGE 81 yrs. 00 mos. 29 ds. IF LESS than 1 day _____ hrs. or _____ min?

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

9 BIRTHPLACE (city or town) (State or country) W. R.

PARENTS
10 NAME OF FATHER W. R. Wood
11 BIRTHPLACE OF FATHER (city or town) (State or country) W. R.
12 MAIDEN NAME OF MOTHER Liffa Irving
13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. R.

14 (Informant) A. L. Wood
(Address) W. R. Ry.

15 Filed 1-15, 1930 J. B. Dancy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-17, 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Dec 17, 1929, that I last saw him alive on Dec 16, 1929, and that death occurred on the date stated above at 8 P. M. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) _____ yrs. _____ mos. 1 ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death? _____
Did an operation precede death? Yes Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. T. Hinton, M. D.
Dec 17, 1929 (Address) W. R. Ry.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Wood Gravel 12-18, 1929

20 UNDERTAKER ADDRESS
John & Susan W. R. Ry.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
M. D.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain text, that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.