

Form V. S. 1-125m-4-15-19

COMMONWEALTH OF KENTUCKY
State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. **21141**
Registered No. **226**
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH
County Clark
Vot. Pct. Ford Registration District No. 240
Inc. Town _____ Primary Registration District No. 5561
City _____ (No. _____ St. _____ Ward _____)

2 FULL NAME Ruby Gene Ashcraft

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> or Divorced <input type="checkbox"/> <u>Infant</u> (Write the word)	16 DATE OF DEATH <u>Oct 19, 1921</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Oct 16, 1921</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 19, 1921</u> , to <u>Oct 19, 1921</u> , that I last saw her alive on <u>Oct 19, 1921</u> , and that death occurred on the date stated above at <u>11:00 a.m.</u>	
7 AGE yrs. _____ mos. <u>3</u> ds. _____ IF LESS than 1 day _____ hrs. _____ or _____ min?			The CAUSE OF DEATH* was as follows: <u>Hepatic Jaundice</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business or establishment in which employed (or employer) _____			(Duration) yrs. _____ mos. <u>3</u> ds.	
9 BIRTHPLACE (State or country) <u>Kentucky</u>			Contributory (Secondary) <u>Undetermined</u>	
PARENTS	10 NAME OF FATHER <u>Harlan Ashcraft</u>		(Duration) yrs. _____ mos. _____ ds.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Kentucky</u>		(Signed) <u>J. S. Pennington, M. D.</u> <u>Oct 20, 1921</u> (Address) <u>Ford Ky</u>	
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Horn</u>		*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.	
13 BIRTHPLACE OF MOTHER (State or country) <u>Kentucky</u>		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, _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Raymond Ashcraft</u> (Address) <u>Ford Ky</u>				
15 Filed <u>Oct 20, 1921</u> <u>Clay Shirley</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Walter grave rd</u> DATE OF BURIAL <u>Oct 20, 1921</u>	
			20 UNDERTAKER <u>James Ashcraft</u> ADDRESS <u>Ford Ky</u>	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain & simple language, so that it may be properly classified. E. I. statement of OCCUPATION is very important. See instructions on back of certificate.

11-5184