

1 PLACE OF DEATH

STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

County *of Meigs*

CERTIFICATE OF DEATH

41409

Vet. Pot. *15'*

Registration District No. *7135*

File No. ....

Ino. Town. *Clatsop Ky*

Primary Registration District No. ....

Registered No. *104*

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

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

2 FULL NAME *not named still born*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>single</i>
6 DATE OF BIRTH <i>Dec 3, 1918</i> (Month) (Day) (Year)		
7 AGE ..... yrs. .... mos. .... ds.		IF LESS than 1 day ... hrs. or ... min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>none</i> (b) General nature of industry business or establishment in which employed (or employer)		

9 BIRTHPLACE (State or country) *Ky.*

PARENTS	10 NAME OF FATHER <i>Charlie Bailey</i>
	11 BIRTHPLACE OF FATHER (State or country) <i>Tenn</i>
	12 MAIDEN NAME OF MOTHER <i>Frankie Snyder</i>
	13 BIRTHPLACE OF MOTHER (State or country) <i>Ky.</i>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Charlie Bailey*  
(Address) *Clatsop Ky*

15 Filed *12-10-18*, 1918 *W. H. Moore*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
*Dec 3, 1918*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Dec 3, 1918*, to *Dec 3, 1918*, that I last saw him alive on *Dec 3, 1918*, and that death occurred on the date stated above at *20*. The CAUSE OF DEATH\* was as follows:  
*Still born Cause unknown*

(Duration) ..... yrs. .... mos. .... ds.  
Contributory (SECONDARY) ..... (Duration) ..... yrs. .... mos. .... ds.  
(Signed) *L. Roy Willis*, M. D.  
*Dec 3, 1918* (Address) *Clatsop 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. State ..... yrs. .... mos. .... ds.  
Where was disease contracted, if not at place of death? .....  
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL <i>Wickliff Ky</i>	DATE OF BURIAL <i>Dec 4, 1918</i>
20 UNDERTAKER <i>J. L. Thomas</i>	ADDRESS <i>Clatsop</i>

WRITE PLAINLY, WITH SPACING 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.