

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

1 PLACE OF DEATH  
County *Muhlenberg*  
Vol. Pot. # *5*  
Ino. Town *Drakesboro, Ky*  
City (No. St., Ward)

Registration District No. *822*  
Primary Registration District No. *2012*

File *24009*  
Registered No. *31*

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

2 FULL NAME *Porter Harrison Calvert*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *January 21, 1823*  
(Month) (Day) (Year)

7 AGE *93* yrs. *8* mos. *9* ds. IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country) *Island, Ky.*

10 NAME OF FATHER *Bennett Garner Calvert*

11 BIRTHPLACE OF FATHER (State or country) *United States*

12 MAIDEN NAME OF MOTHER *Henrietta Clark,*

13 BIRTHPLACE OF MOTHER (State or country) *(Not known)*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Ruth E. Calvert,* (Address) *Drakesboro, Ky.*

15 Filed *10/1*, 1916 *J. H. ...* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *September 30, 1916*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 7, 1916,* to *Sept 30, 1916,* that I last saw him alive on *Sept 30, 1916,* and that death occurred on the date stated above at *7 P. m.* The CAUSE OF DEATH\* was as follows:

*Chronic Diarrhea*  
(Duration) *6* yrs. *6* mos. *6* ds.

Contributory (SECONDARY) (Duration) *6* yrs. *6* mos. *6* ds.

(Signed) *H. D. Newman,* M. D. *Sept 30, 1916.* (Address) *Drakesboro, Ky.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, the (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 *6* yrs. *6* mos. *6* ds. State *6* yrs. *6* mos. *6* ds.

Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Ebenezer Graveland* DATE OF BURIAL *Oct 1, 1916*

20 UNDERTAKER *J. H. House & Co., Drakesboro, Ky.* ADDRESS

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.