

1 PLACE OF DEATH

STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

County *Muhlenberg*

CERTIFICATE OF DEATH

Vot. Pot.

Registration District No. *7126*

File No. ....

Ino. Town *Parish*Primary Registration District No. *2565*

Registered No. ....

City

(No. .... Ward)

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

2 FULL NAME *Count Pulaski Gregory*

## PERSON AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*6 DATE OF BIRTH *April 6, 1891*  
(Month) (Day) (Year)7 AGE *25 yrs. F. 25' ds.* IF LESS than 1 day ... hrs. or ... min.?8 OCCUPATION (a) Trade, profession, or particular kind of work. *Farmer* (b) General nature of industry, business or establishment in which employed (or employer)9 BIRTHPLACE (State or country) *Ky*10 NAME OF FATHER *Morn Gregory*11 BIRTHPLACE OF FATHER (State or country) *Penn*12 MAIDEN NAME OF MOTHER *Lucinda Morris*13 BIRTHPLACE OF MOTHER (State or country) *Ind*14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Morn Gregory* (Address) *Parish*15 Filed *Jan 3, 1917* *A. B. Smith* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 1, 1917*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Dec 27, 1917*, to *Jan 1, 1917*, that I last saw him alive on *Jan 1, 1917*, and that death occurred on the date stated above at *10 A.M.* The CAUSE OF DEATH\* was as follows:*Rheumatism followed by organic and valvular defect trouble*(Duration) ... yrs. ... mos. *7* de.

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

(Signed) *LeRoy Phillips*, M. D. *Jan 1, 1917* (Address) *Cleaton 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 *Cemetery* DATE OF BURIAL20 UNDERTAKER *Walter Moore* ADDRESS *Central City*

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 certified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.