

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

PLACE OF DEATH

County *Muhlenberg*

Vol. Pat. # *3*

Inn. Town *Central City*

City (No. St. Ward)

870
7123

24007
 File No. _____
 Registered No. *51*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME *Olinus Perry*

PERSONAL AND STATISTICAL PARTICULARS

1 SEX *Male* **2 COLOR OR RACE** *white* **3 SINGLE, MARRIED, WIDOWED, OR DIVORCED** *Married*
(Write the word)

4 DATE OF BIRTH *8 - 18, 1875*
(Month) (Day) (Year)

7 AGE *21* yrs. *24* mos. *24* ds.
If LESS than 1 day.... hrs. or... min.?

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

9 BIRTHPLACE (State or country) *Muhlenberg Co*

10 NAME OF FATHER *Jake Perry*

11 BIRTHPLACE OF FATHER (State or country) *Tenn.*

12 MAIDEN NAME OF MOTHER *Mary Josie*

13 BIRTHPLACE OF MOTHER (State or country) *Muhlenberg Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) *Sessie Humphreys*
 (Address) *Central City*

15 *Set 6, 1914*
 Filed *Q. L. Blandford*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH *9 - 12, 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *7-28, 1914*, to *9-12, 1914*

that I last saw him alive on *9-12, 1914*
 and that death occurred, on the date stated above, at *P.O.m.*

The **CAUSE OF DEATH*** was as follows:
Abscess of Throat

(Duration) yrs. mos. *4* ds.

Contributory *By fluid from*
(Secondary) (Duration) yrs. mos. *1* ds.

(Signed) *J. H. Zales*, M. D.
 (Address) *Central City*, 191...

*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.
 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 *Coleman Cemetery* **DATE OF BURIAL** *9-13, 1914*

20 UNDERTAKER *Master Moore* **ADDRESS** *Central City, Ky.*

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 terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.