FORM V S 1-500M.

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No. 21954

1 PLACE OF DEATH
County Muhlenburg
Vot. Pct. ....
Ino. Town ....
City Greenville

Registration District No. 871
Primary Registration District No. 2436
(No. .... St., ... Ward)

Registered No ....
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Clarence R. Saulsbury

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Col.
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Jan. 25", 1903 (Month) (Day) (Year)

7 AGE: 16 yrs. 6 mos. — ds.
IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country): Kentucky

PARENTS
10 NAME OF FATHER: Julius Saulsbury
11 BIRTHPLACE OF FATHER (State or country): Kentucky
12 MAIDEN NAME OF MOTHER: Ella Hancock
13 BIRTHPLACE OF MOTHER (State or country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella H Harbin
(Address) Greenville, Ky.

15 Filed 7/16, 1919 C. Berkley, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 15", 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 9", 1918, to July 15", 1919, that I last saw him alive on July 15", 1919, and that death occurred on the date stated above at 6 a.m. The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(Duration) 1 yrs. 6 mos. ...... ds.

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

(Signed) W. S. Porter, M. D.
July 15", 1919 (Address) Greenville, 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: [illegible]
DATE OF BURIAL: July 16, 1919

20 UNDERTAKER: [illegible]
ADDRESS: Greenville Ky

11—3184

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.