

1 PLACE OF DEATH

County *Muhlenberg*

Vot. Pot. *2*

Ino. Town *Cleatory*

City (No. St. Ward)

2 FULL NAME *Corneil Terrence Sears*

Commonwealth of Kentucky

STATE BOARD OF HEALTH
DEPARTMENT OF VITAL STATISTICS
CERTIFICATE OF DEATH

16866

File No.

Registered No. *180*

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

Registration District No. *7135*

Primary Registration District No.

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *May 17, 1889*
(Month) (Day) (Year)

7 AGE *31* yrs. *2* mos. *21* ds. IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country) *Kentucky*

PARENTS
10 NAME OF FATHER *Samuel O. Sears*
11 BIRTHPLACE OF FATHER (State or country) *Kentucky*
12 MAIDEN NAME OF MOTHER *Sallie G. Smith*
13 BIRTHPLACE OF MOTHER (State or country) *Kentucky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *W.D. Sears*
(Address) *Cleatory, Ky.*

15 Filed *June 6, 1920* *W.H. Moore* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 5, 1920*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *June 3, 1920*, to *June 5, 1920*, that I last saw him alive on *June 5, 1920* and that death occurred on the date stated above at *2* a.m. The CAUSE OF DEATH* was as follows:

Homicide, by firearm
(Duration) ... yrs. ... mos. ... ds.

Contributory (SECONDARY) (Duration) ... yrs. ... mos. ... ds.
(Signed) *C. D. Adams*, M. D.
June 5, 1920 (Address) *Cleatory, 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 *Graveyard* DATE OF BURIAL *June 6, 1920*
20 UNDERTAKER *J. L. Thomas* ADDRESS *Cleatory, Ky.*

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.