

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

1 PLACE OF DEATH

County *Muhlenberg*

Vol. Pot. *Paradise, Ky*

Ino. Town.....

City..... (No..... St.,..... Ward)

2 FULL NAME *William H. Smith*

Registration District No. *1089*

Primary Registration District No. *6823*

File No.....

Registered No. *3*

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *m* 4 COLOR OR RACE *w* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED

6 DATE OF BIRTH *Sept 30 1881* (Month) (Day) (Year)

7 AGE *53 yrs 9 mos 6 ds* IF LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (State or country) *Ohio Co, Ky*

PARENTS 10 NAME OF FATHER *Leeward Smith* 11 BIRTHPLACE OF FATHER (State or country) *Muhlenberg Co, Ky* 12 MAIDEN NAME OF MOTHER *Elizabeth Yates* 13 BIRTHPLACE OF MOTHER (State or country) *Ohio Co, Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Charles Smith* (Address) *Paradise, Ky*

15 Filed *July 9, 1925* *W.S. Cundiff* REGISTRAR *My Laura A. Brown*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 6 1925* (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased *Jan 1920*, 191...., to *July 6 25*, 192...., that I last saw him alive on *July 2 25*, 192...., and that death occurred on the date stated above at *10:30*. The CAUSE OF DEATH* was as follows:

Presumbility

Contributory *Old Age* (Duration) *7* yrs.... mos.... ds.

(Signed) *Geo. L. Carlier* M. D. (Address) *Rockport, 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 *Smith Cemetery* DATE OF BURIAL *July 7, 1925*

20 UNDERTAKER *J.F. Carlier* ADDRESS *Beaver Dam, Ky*

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.