FORM V S 1-2000M 2-29-12

1 PLACE OF DEATH

County ..MUHLENBERG.....

Vot. Pct. ..46.....

XXXX Town ..PARADISE....KY.....

City .....

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

File No. 25404

Registration District No. 2126

Registered No. .....

Primary Registration District No. 2968

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

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

2 FULL NAME ..... ESTIL WEST .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
MALE	WHITE	SINGLE

6 DATE OF BIRTH ..... AUGUST (Month) ..... 1 (Day) ..., 1908 (Year)

7 AGE ..... 7 ..... yrs. ... 2 ... mos. ..... da.

IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country)
PARADISE KY

PARENTS

10 NAME OF FATHER
CHARLEY WEST

11 BIRTHPLACE OF FATHER (State or country)
McLEAN COUNTY KY

12 MAIDEN NAME OF MOTHER
KATIE BUCHANAN

13 BIRTHPLACE OF MOTHER (State or country)
MUHLENBERG COUNTY KY

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ..M. W. ROARK.....

(Address) ..... PARADISE ..... KY .....

15 Filed Oct. 8..., 1915 Kirby K. Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... OCTOBER (Month) ... 1, (Day) ..... 1915 (Year)

17 I HEREBY CERTIFY, That I attended deceased from SEPT. 25..., 1915, to OCTOBER 1., 1915., that I last saw him alive on SEPTEMBER 30, 1915., and that death occurred on the date stated above at 9a. m. The CAUSE OF DEATH* was as follows:

..... ACUTE NEPHRITIS .....

.....

.....

.....(Duration) ..... yrs. ..... mos. ... 7 ... da.

Contributory (SECONDARY) ..... DIPTHERIA .....

.....(Duration) ..... yrs. ... 1 ... mos. ..... da.

(Signed) ..... N. D. Newman ....., M. D.

OCT. 1, ..., 1915 (Address) DRAKESBORO ..... 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. ..... da. In the State ..... yrs. ..... mos. ..... da.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
WEIR GRAVEYARD	OCT. 3..., 1915
20 UNDERTAKER	ADDRESS
RUFUS ROSE	CLEATON KY

11—3184

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 clearly understood. Each statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE RESERVED FOR BINDING