

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 Every item of information should be correctly spelled. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it can be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH (Dist. No. _____)
 (To be inserted by Registrar)

County Logan

District _____
 or _____

Town or City Accoville W Va St. _____ Ward _____

2 FULL NAME Clyde Goldy

West Virginia State Department of Health
 BUREAU OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Register No. 4251

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____
 (Month) (Day) (Year)

7 AGE 4 IF LESS THAN 1 day, ____ hrs. ____ yrs. ____ mos. ____ ds. or ____ wks. 7

8 OCCUPATION
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which engaged (or employee).

9 BIRTHPLACE (State or country) Kentucky

10 NAME OF FATHER Joe Goldy

11 BIRTHPLACE OF FATHER (State or country) Ky

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature) Joe Goldy

(Address) Accoville, W Va

15 Registrar _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12/24/18
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____ 191__ to _____ 191__

that I last saw him alive on _____ 191__

and that death occurred on the date stated above, at _____

The CAUSE OF DEATH was as follows:

189
 (Duration) yrs. mos. ds.

Contributory (SECONDARY) _____

(Duration) yrs. mos. ds.

(Signed) _____ M. D.

191__ (Address) _____

NOTE: State the DISEASE CAUSING DEATH. In deaths from TYPHOID FEVER, State MALARIA or TYPHUS; and whether ACUTE, CHRONIC, or HEMICRAL.

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 Salt Lick Ky DATE OF BURIAL 191__

20 UNDERTAKER LOGAN MERCANTILE CO ADDRESS LOGAN W VA