1952759_0002948

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every line of information should be carefully supplied. AGE should be entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may 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 (Ms _____ St.; _____ Ward)

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

2 FULL NAME Clyde Goldy

West Virginia State Department of Health
BUREAU OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Register No. 4251

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 yrs. _____ 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)

9 BIRTHPLACE (State or country) WenYucky

PARENTS

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

(Informant) Joe Goldy

(Address) Accoville, W. Va.

15 Filed _____, 191 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12/24/18 (Month) (Day) , 191 (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191__, to _____, 191__, that I last saw h__ alive on _____, 191__, and that death occurred, on the date stated above, at ___m.

The CAUSE OF DEATH was as follows:

1 8 9 1

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____, M. D.

_____, 191__ (Address) _____

NOTE: State the Disease Causing Death. In deaths from Violent Causes, State Means of Injury; and 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: Salt Lick Ky

DATE OF BURIAL _____, 191__

20 UNDERTAKER: LOGAN MERCANTILE CO

ADDRESS: LOGAN W VA