FORM V S 1-1004

Commonwealth of Kentucky
STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Bath

Vet. Pct. 5106 Registration District No. 52

Inc. Town ..... Primary Registration District No. 5106

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

File No. 21341

Registered No. .....

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

2 FULL NAME Virgil Goldie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): single

6 DATE OF BIRTH: June 3, 1917 (Month) (Day) (Year)

7 AGE: ..... yrs. 2 mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country): Bath Co. Ky.

PARENTS

10 NAME OF FATHER: Alfred Goldie

11 BIRTHPLACE OF FATHER (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Effie Thornsburg

13 BIRTHPLACE OF MOTHER (State or country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. C. T. Jones

(Address) Salt Lick, Ky.

15 Filed 8/3, 1917 S. C. Alexander, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 3, 1917 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1917, to June 6, 1917, that I last saw him alive on June 6, 1917, and that death occurred on the date stated above at 5:30 A.M. The CAUSE OF DEATH* was as follows:

Rickets

..... (Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

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

(Signed) C. T. Jones M. D.

Aug 3, 1917 (Address) Salt Lick, 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: Jones Grove Yard

DATE OF BURIAL: 8/4, 1917

20 UNDERTAKER: Mrs J. W. Vaughan

ADDRESS: Salt Lick

11—3194

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

H. 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.