Form V. S. 1-[illegible]-1-27-27

1 PLACE OF DEATH

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

D. Barnton
307 [illegible] Rd.

File No. 16920

Registered No. 585

County Fayette

Vot. Pct. ____

Registration District No. 3

Inc. Town ____

City Lexington Ky

Primary Registration District No. 2665

(No. ____ St., ____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mitchell Cassity

(a) Residence. No. 111 Hagerman Court ____ Ward.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed or Divorced (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH: Oct 2 [illegible] (Month) (Day) (Year)

7 AGE: 23 yrs. 9 mos. 4 ds. If LESS than 1 day ____ hrs. or ____ min?

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Asst Mgr.
(b) General nature of industry, business or establishment in which employed (or employer): Bookstore / [illegible]

9 BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10 NAME OF FATHER: E. T. Cassity

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Iona Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 (Informant) Mrs E. T. Cassity
(Address) 111 Hagerman Court

15 Filed July 14, 1928 D. A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 6, 1928 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1928, to July 6, 1928; that I last saw him alive on July 6, 1928 and that death occurred on the date stated above at [illegible]

The CAUSE OF DEATH* was as follows:
Tubercular meningitis

(Duration) ____ yrs. 1 mos. ____ ds.

Contributory (Secondary): Pulmonary Tuberculosis

(Duration) 1 yrs. ____ mos. ____ ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? [illegible]

(Signed) J. D. Barnton, M. D.
7-6-1928 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL: Frankfort Ky.

DATE OF BURIAL: July 8 1928

20 UNDERTAKER: W. R. Milward

ADDRESS: Lex 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.

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