FORM V. S. 1-5000 2-9-12

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

File No. 8020

Registered No. 67

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

1 PLACE OF DEATH

County Rowan

Vot. Pct. Farmers Registration District No. 7492

Inc. Town ..... Primary Registration District No. 2506

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

2 FULL NAME Dearwood Cassity

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: May 18th, 1900 (Month) (Day) (Year)

7 AGE: 18 yrs. 9 mos. 6 ds. IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Rowan Co.

PARENTS

10 NAME OF FATHER: Price Cassity

11 BIRTHPLACE OF FATHER (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Dora Gray

13 BIRTHPLACE OF MOTHER (State or country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. W. Cassity

(Address) Farmers Ky.

15 Filed Feb 26, 1919 Parmelia Myre (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 25 (Month) (Day), 1919 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1919, to Feb 25, 1919, that I last saw him alive on Feb 25, 1919, and that death occurred on the date stated above at 9 p.m. The CAUSE OF DEATH* was as follows:

Hemorage from Bowels

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

Contributory (Secondary): Influenza

(Duration) ... yrs. ... mos. 14 ds.

(Signed) Dr. Thos. Williams, M. D.

Feb 26, 1919 (Address) Farmers

*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 cemetery DATE OF BURIAL: Feb 26, 1919

UNDERTAKER: Thos. F. Vaughn ADDRESS: Salt Lick Ky.

11—3154

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.