

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

County Bath File No. 28994
 Vol. No. 1706 Registration District No. 92 Registered No. _____
 Inc. Town _____ Primary Registration District No. _____
 City _____ No. _____ St. _____ Ward _____
 (If death occurred in a hospital or institution, give the name thereof and street and number.)

FULL NAME Chester Clark

R. S. Every item of information should be obtained 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.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White MARRIAGE STATUS Single
 (MARRIED, WIDOWED, DIVORCED, SEPARATED, NEVER MARRIED)

DATE OF BIRTH Nov. 1918
 (Month) (Day) (Year)

AGE 1 yr. (If less than 1 day, give hr. or min.)

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

BIRTHPLACE (State or country) Bath Co. Ky

NAME OF FATHER Spencer Clark

BIRTHPLACE OF FATHER (State or country) Bath Co. Ky

Maiden name of MOTHER None

BIRTHPLACE OF MOTHER (State or country) Bath Co. Ky

IS THE ABOVE TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Wm. H. Gentry
 (Address) Salt Lick, Ky

FILED Nov. 24, 1919 BY Wm. H. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 23, 1919
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1919 to Nov. 22, 1919, that I last saw him alive on Nov. 22, 1919, and that death occurred on the date stated above at _____ m. The CAUSE OF DEATH was as follows:
Croup
 (Duration) yr. mos. ds.

Contributory (Cause) _____ (Duration) yr. mos. ds.

(Signed) E. P. Sawyer, M. D.
Nov. 19, 1919 (Address) Salt Lick, Ky

Was the Disease Caused or Exacerbated by (a) One or More of the Following Causes state (1) Name of Injury (2) Whether ACCIDENTAL, OCCIDENTAL, OCCURRENCE OF OCCURRENCE

LENGTH OF RESIDENCE (If in hospital, institution, farm, boarding house, etc.) _____
 At place of death yr. mos. fs. State yr. mos. ds.

Where was disease contracted, if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL ON REMOVAL _____ DATE OF BURIAL _____
James G. Gentry Nov. 24, 1919
 (Address) Salt Lick, Ky