

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

18776
 File No.
 Registered No. **442**
 (If death occurred in a hospital or institution give the NAME (instead of street and number.)

1 PLACE OF DEATH
 Country **Bath**
 Vol. No. **Salt Lake** Registration District No. **52**
 Inc. Town Primary Registration District No. **5106**
 City (No. St. Ward)

2 FULL NAME **Eugene Lgo**

WRITE PLAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD
 M. 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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Boy** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____

6 DATE OF BIRTH **June 2, 1920**
 (Month) (Day) (Year)

7 AGE **1 yrs. 2 mos. 23 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) **Bath Co.**

PARENTS

10 NAME OF FATHER **G. W. Lgo**

11 BIRTHPLACE OF FATHER (State or country) **Morgan Co., Ky.**

12 MAIDEN NAME OF MOTHER **Ethel Perry**

13 BIRTHPLACE OF MOTHER (State or country) **Morgan Co., Ky.**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) **G. W. Lgo**
 (Address) **Farmers Ky.**

15 **Augustus Parmel Myers**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

14 DATE OF DEATH **Aug 25, 1921**
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **Aug 23, 1921**, to **Aug 25, 1921**, that I last saw him alive on **Aug 25, 1921**, and that death occurred on the date stated above at **11:30 a.m.** The CAUSE OF DEATH* was as follows:
Enteritis
 (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) **John Detko**, M. D.
 (Address) **Farmers**

*Was the DEATH CAUSED BY DEATH, or, in death from VIOLENT CAUSE and (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL OR HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS 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 **Yours cemetery** DATE OF BURIAL **Aug 26, 1921**
 (Address) **Ed. H. Myers Farmers**