Form V. S. 1—50m—1-27-27

COMMONWEALTH OF KENTUCKY

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 23821
Registered No. 63

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. .... Registration District No. 1087

Inc. Town Central City Primary Registration District No. 2435

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

2 FULL NAME Robert W. Casebier

(a) Residence. No. .... St., ... 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: Male

4 COLOR OR RACE: White

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

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

6 DATE OF BIRTH: March (Month) 5th (Day) 1841 (Year)

7 AGE: 86 yrs. 7 mos. 14 ds. IF LESS than 1 day ...... hrs. or ...... min?

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

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

PARENTS

10 NAME OF FATHER: Benjamin Casebier

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

12 MAIDEN NAME OF MOTHER: Mary Hilton

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

14 (Informant) B. W. Casebier
(Address) Bremen Ky

15 Filed 11-1, 1927 A. L. Blanford Registrar
N 29 / 12-22-27

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 19th (Day), 1927 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1927, to 10/17, 1927, that I last saw h... alive on 10/15, 1927, and that death occurred on the date stated above at 4:00 a.m.

The CAUSE OF DEATH* was as follows:
Uraemic Poisoning
(Duration) ... yrs. ... mos. 9 ds.

Contributory (Secondary): Hypertrophy of Prostate
(Duration) 3 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? ....
(Signed) [illegible] M. D.
10-19, 1927 (Address) [illegible]

*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: Evergreen Cemetery
DATE OF BURIAL: 10-21, 1927

20 UNDERTAKER: E. J. Anderson
ADDRESS: Central City Ky

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.