FORM V S 1-500M

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

20312

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. #18 — Registration District No. 870 — File No. ....

Inc. Town Central City — Primary Registration District No. 2435 — Registered No. 21

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

2 FULL NAME Beverly Inez Naffzenger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): ....

6 DATE OF BIRTH: May (Month) 30 (Day), 1921 (Year)

7 AGE: .... yrs. 2 mos. 10 ds. — IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Central City, Ky

PARENTS

10 NAME OF FATHER: S. B. Naffzenger

11 BIRTHPLACE OF FATHER (State or country): Muhlenberg Co K

12 MAIDEN NAME OF MOTHER: Ecla Downs

13 BIRTHPLACE OF MOTHER (State or country): Muhlenberg Co K

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. B. Naffzenger

(Address) Central City, K

15

Filed 8/12 1921 A. L. Blanchard — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 8 (Month) - 11 (Day), 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 11, 1921, that I last saw him alive on Aug 10, 1921, and that death occurred, on the date stated above at 2 ½ a.m. The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal indigestion

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

Contributory (SECONDARY) Malnutrition.

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

(Signed) W. C. McNeil, M. D.

8-11, 1921 (Address) Central City Ky

*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: Gishton, Ky — DATE OF BURIAL: Aug 12, 1921

20 UNDERTAKER: [illegible] — ADDRESS: Central City, Ky

11-3196

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.