

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

PLACE OF DEATH

County *Muhlenberg*Vol. No. *15*Registration District No. *2135*Inc. Town *Cleaton Ky*

Primary Registration District No.

City

(No. St., Ward)

FULL NAME *William P. Rose*File No. *3155*Registered No. *104*

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

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 *Oct 27, 1907*
(Month) (Day) (Year)

7 AGE *10 yrs. - 27 ds.* IF LESS than 1 day ... hrs. or ... min.?

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

9 BIRTHPLACE (State or country) *Muhlenberg co Ky*

10 NAME OF FATHER *M. B. Rose*

11 BIRTHPLACE OF FATHER (State or country) *Muhlenberg co Ky*

12 MAIDEN NAME OF MOTHER *Fannie M. Casbier*

13 BIRTHPLACE OF MOTHER (State or country) *Muhlenberg co Ky*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *D. P. Casbier*
(Address) *Central City Ky*

15

Filed *Nov 24, 1917* *W. H. ...*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 23, 1917*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct 10, 1917, to Nov 23, 1917*, that I last saw *him* alive on *Nov 23, 1917*, and that death occurred on the date stated above at *11:20 p.m.*, The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration) ... yrs. *1* mos. *15* ds.

Contributory (SECONDARY)
(Signed) *W. P. M. Dowell*, M. D.
Nov 24, 1917 (Address) *Central City*

*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, TRANSPORTS 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 *Rose & Co* DATE OF BURIAL *11/24, 1917*

20 UNDERTAKER *J. L. Thomas* ADDRESS *Cleaton Ky*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
B. E.--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.