FORM V S 1-500M

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

1 PLACE OF DEATH

County Muhlenberg

Vot. Pct. E. Baggets

Registration District No. 871

File No. 20474

Registered No. 7132

Inc. Town .... Primary Registration District No. ....

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

2 FULL NAME E. S. Underwood

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: Mch 5, 1882 (Month) (Day) (Year)

7 AGE: 33 yrs. .... mos. .... ds. IF LESS than 1 day... hrs. or ... min.?

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

9 BIRTHPLACE (State or country): Muhlenberg Co.

PARENTS

10 NAME OF FATHER: E. M. Underwood

11 BIRTHPLACE OF FATHER (State or country): Tenn

12 MAIDEN NAME OF MOTHER: Effie Sarah Wright

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. B. Vincent

(Address) Graham, Ky

15

Filed Aug 6, 1915 C. B. Wickliffe, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 5, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1915, to August 5, 1915, that I last saw him alive on August 5, 1915, and that death occurred on the date stated above at 2 a.m. The CAUSE OF DEATH* was as follows:

Necrosis of inner ear and septicaemia

(Duration) 12 yrs. .... mos. .... ds.

Contributory (SECONDARY): Pneumonia

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

(Signed) Henry H. Slaton, M. D.

Aug. 6, 1915. (Address) Greenville 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: East Union

DATE OF BURIAL: Aug 7, 1915

20 UNDERTAKER: Chas. Croft

ADDRESS: Graham, Ky

11—3164

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD