

## COMMONWEALTH OF KENTUCKY

State Board of Health  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11727

PLACE OF DEATH  
County *Mehlenberg*

File No. ....

Vol. Pct. *2 35*Registration District No. *1094*Registered No. *104*

Inc. Town. ....

Primary Registration District No. *6541*

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

City. .... (No. .... St., .... Ward)  
3 FULL NAME *Louis David Sought*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single Married *Married* Widowed or Divorced (Write the word)6 DATE OF BIRTH *11 3 85*  
(Month) (Day) (Year)7 AGE *35* yrs. *6* mos. *17* ds. IF LESS than 1 day ..... hrs. or ..... min?8 OCCUPATION (a) Trade, profession or particular kind of work. *Welder* (b) General nature of industry, business or establishment in which employed (or employer).9 BIRTHPLACE (State or country) *Kentucky*

## PARENTS

10 NAME OF FATHER *William W Sought*11 BIRTHPLACE OF FATHER (State or country) *Kentucky*12 MAIDEN NAME OF MOTHER *Dorcas Dunn*13 BIRTHPLACE OF MOTHER (State or country) *Kentucky*14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Geo. Sought*(Address) *Clintons*15 Filed *May 30*, 1927 *Vannie Thomas* Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *5 20 1927*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *7/12/27*, 1927, to *7/20/27*, 1927, that I last saw him alive on *7/20/27*, 1927, and that death occurred on the date stated above at *6:00* a.m.The CAUSE OF DEATH\* was as follows:  
*Chronic Interstitial Nephritis*  
(Duration) *9* yrs. .... mos. .... ds.Contributory (Secondary) .....  
(Duration) ..... yrs. .... mos. .... ds.(Signed) *C. D. Ryan*, M. D. *May 20* 1927 (Address) *Clintons*

\*State the Disease Causing Death, or, in deaths from Violent Cause, 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 ..... 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 G. Y* DATE OF BURIAL *May 30* 192720 UNDERTAKER *J. Thomas* ADDRESS *Clintons*

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

N. B.—Every item of information should be carefully supplied. AGE should be 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.