

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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.

Form T. & S. 1-A
DEPARTMENT OF COMMERCE
Bureau of the Census

COMMONWEALTH OF KENTUCKY
Department of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. **28085**
Registrar's No. **293**

Registration District No. **1085** Primary Registration District No. **7471**

1. PLACE OF DEATH: (a) County **Magdalena** (b) City or town **Rural** (c) Name of hospital or institution: _____ (If not in hospital or institution write street number or location) (d) Length of stay: in hospital or community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED: (a) State **Kentucky** (b) County **Magdalena** (c) City or town **Rural** (If outside city or town (limits write RURAL)) (d) Street No. _____ (If rural give precinct) (e) If foreign born, how long in U. S. A. _____ year

3(a) FULL NAME **Clagel Dick**
3(b) If veteran, Name war _____ 3(c) Social Security No. _____
4. Sex **M** 5. Color or race **W** 6(a) Single, widowed, married, divorced **Married**
6(b) Name of husband or wife _____
6(c) Age of husband or wife if alive _____ Years
7. Birth date of deceased (Month) (Day) (Year) **1893**
8. AGE: Years **50** Months _____ Days _____ If less than one day hr. min.
9. Birthplace **Kentucky**
10. Usual occupation **at home**
11. Industry or business _____
FATHER { 12. Name **Edwood Griffin**
13. Birthplace **Ky**
MOTHER { 14. Maiden name **Elara Griffin**
15. Birthplace **Ky**
16(a) Informant's own signature **Charles Dick**
(b) Address **Central City Ky**
17. BURIAL, CREMATION, OR REMOVAL **Paul Fullmer** Date **11-19-1943**
18(a) Signature of funeral director **J. J. Anderson**
(b) Address **Central City Ky**
19(a) **12-10-43** (Date received by local registrar) (b) **James H. Powell** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH **November 17 1943**
21. I hereby certify that I attended the deceased from **Nov 15 1943** to **Nov 17 1943** that I last saw he alive on **Nov 17 1943** and that death occurred on the date stated above at **4:30 P. M.**
Immediate cause of death **Death followed operations for gall stones & appendicitis (about 2 months before all symptoms started) Spicy & brown stool**
Other conditions: (Include pregnancy within 3 months of death) **I do not know cause**
Major findings: **121-126**
Of operations _____
Of autopsy _____
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? in or about home, on farm, in industrial place in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **J. S. Fitzhugh** (M. D. or other)
Address **Central City Ky** **11/20/43**

DURATION: **27.3**
months