If NON-RESIDENT, be careful to give the complete residence of the deceased, stating both city, county and state. The residence is the usual place of abode.

1 PLACE OF DEATH
STATE OF TEXAS

TEXAS DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

24470

Registrar's No. 1646

COUNTY OF Bexar

CITY OR PRECINCT NO. San Antonio, Tex No. 404 Street Broadway
If in an institution, give name of institution instead of Street and No.

Length of residence in city where death occurred 3 yrs. ...... mos. ...... days. How long in U. S. if foreign born? ...... yrs. ...... mos. ...... days

2 FULL NAME OF DECEASED John Lincoln Clem

RESIDENCE OF THE DECEASED No. 404 Street Broadway City San Antonio State Texas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, Divorced (Write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Sullivan Clem

6. DATE OF BIRTH (month, day, and year) Aug., 13, 1851

7. AGE 85 Years 9 Months 0 Days. If LESS than 1 day ...... hrs. or ...... min

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Major

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. General U.S. Army

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (City or Town) (State or Country) Newark, Ohio

FATHER

13. NAME Roman Clem

14. BIRTHPLACE (City or Town) (State or Country) No record

MOTHER

15. MAIDEN NAME Magadelene Weaver

16. BIRTHPLACE (City or Town) (State or Country) No record

17. INFORMANT Mrs. Elizabeth Sullivan Clem

(Address) 404 Broadway, San Antonio, Texas

18. BURIAL Washington, D. C.

REMOVAL Place Date May 16, 1937

19. UNDERTAKER Zizik-Kearns Undertaking Co.,

(Address) 822 E. Houston Joseph W. Kearns

20. SIGNATURE AND FILE DATE OF LOCAL REGISTRAR

MAY 1 . 1937 193.. [signature]

(File Date) (Signature)

MEDICAL PARTICULARS

21. DATE OF DEATH (month, day, and year) May 13, 1937

22. I HEREBY CERTIFY, That I attended deceased from for past 11 yrs. 193.. to ...... 193..

I last saw him alive on May 13 1937; death is said to have occurred on the date stated above, at 5:45 P.m.

The principal cause of death and related causes of importance were as follows: Dilatation of heart, Inf[illegible] heart

Date of Onset: [illegible]

Other contributory causes of importance: Senility

Name of operation none Date of ......

What test confirmed diagnosis? ...... Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?

Date of injury ...... 193..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. M. Wolf [signature] M.D.

(Address) Nix Bldg., San Antonio, Texas

RECEIVED JUN 10 1937 TEXAS — DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS

TEXAS STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

Registrar's No. 51344

1. PLACE OF DEATH STATE OF TEXAS
COUNTY OF DUVAL
CITY OR PRECINCT NO. SAN DIEGO No. Street
If in an Institution, give name of Institution instead of Street and No.

Length of residence in city where death occurred ___ yrs. ___ mos. ___ days. How long in U. S. if foreign born? ___ yrs. ___ mos. ___ days.

2. FULL NAME OF DECEASED JAMES O. LUBY

Residence: No. Martinez Hotel
If non-residence give city, or town and state

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, Divorced (Write the word) Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day, and year) JUNE 14 TH. 1846
7. AGE 86 Years 5 Months 25 Days. If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. LAWYER
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. COURTS
10. Date deceased last worked at this occupation (month and year) JAN. 1932
11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (city or town) (State or country) LONDON ENGLAND

FATHER
13. NAME DANIEL LUBY
14. BIRTHPLACE (city or town) (State or country) LONDON, ENGLAND.

MOTHER
15. MAIDEN NAME CATHERINE SMITH
16. BIRTHPLACE (City or town) (State or county) IRELAND

17. INFORMANT John M. Luby
(Address) CORPUS CHRISTIE

18. BURIAL, CREMATION OR REMOVAL Vault
Place San Diego Tex. Date Dec 10 1932

19. UNDERTAKER Moya Mortuary
(Address) Alice Tex

20. FILE DATE AND SIGNATURE OF REGISTRAR
12/14 19 32 [illegible signature]

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) DEC. 9 TH. 1932

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1932, 19 ___ to DEC. 9 TH 1932

I last saw him alive on Dec 9 Th 1932; death is said to have occurred on the date stated above, at 12.30 P. m.

The principal cause of death and related causes of importance were as follows: Influenza. Pulmonary Emphysema. Age

Date of onset: Dec 1/32

Other contributory causes of importance:

Name of operation ___ date of ___

What test confirmed diagnosis? ___ Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?
Date of injury ___ 19 ___
Where did injury occur? (Specify city or town, county and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) R. C. Elliott M. D.
(Address) # 271 SAN DIEGO TEXAS.

RECEIVED BUREAU OF VITAL STATISTICS JAN 9 1933 TEXAS

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

MARGIN RESERVED FOR BINDING

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.

STATE OF TENNESSEE

199

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Giles

Civil Dist. 15 or Village Lynnville or City ....(No. .... St.; .... Ward)

Registration District No. 282

Primary Registration District No. 42815

File No. 423

Registered No. ....

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

2 FULL NAME J. K. P. Blackburn

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Male; 4 COLOR OR RACE: White; 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed	16 DATE OF DEATH: July 6 (Month) (Day) 192 3 (Year)
6 DATE OF BIRTH: .... (Month) .... (Day) 1.... (Year)	17 I HEREBY CERTIFY, That I attended deceased from June 192 3, to July 6, 192 3, that I last saw h.. alive on July 5 192 3 and that death occurred, on the date stated above, at 11 30 A M.
7 AGE: 86 yrs. .... mos. .... ds. If LESS than 1 day, ... hrs. or .... min.?	The CAUSE OF DEATH* was as follows: Acute dilatation of heart decline few minutes — 90
8 OCCUPATION (a) Trade, profession, or particular kind of work: Farmer 060 (b) General nature of industry, business, or establishment in which employed (or employer)	[Duration] .... yrs. .... mos. .... ds.
9 BIRTHPLACE (State or country): Maury Co. Tenn	Contributory (SECONDARY): Heart Block
PARENTS 10 NAME OF FATHER: Edward Blackburn	[Duration] 1 yrs. .... mos. .... ds.
11 BIRTHPLACE OF FATHER [State or country]: Maury Co Tenn	Signed Joe Burgess M. D. July 6 192 3 Address Lynnville Tenn
12 MAIDEN NAME OF MOTHER: Mackie Laird	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
13 BIRTHPLACE OF MOTHER [State or country]: Giles Co	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 ....
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) R. E. Blackburn (Address) Lynnville Tenn	19 PLACE OF BURIAL OR REMOVAL: Lynnville; DATE OF BURIAL: July 8 192 3
15 Filed Aug 12 192 3 R. L. Wagstaff REGISTRAR	20 UNDERTAKER: J. H. Gray; ADDRESS: Lynnville

1 PLACE OF DEATH 30468
Harris.
County

TEXAS STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

Reg. Dis. No. 43217
Registered No. 774
B.O.V.S. FORM D

City Houston (No. 1906 McKinney. Ave. St.; Ward)

2 FULL NAME Samuel Swan Ashe. (a) RESIDENCE. No. St.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Wid.

6 DATE OF BIRTH June 14. 837
(Month) (Day) (Year)

7 AGE 81 yrs. 10 mos. 15 ds.
If less than 2 years state if breast fed: Yes No. If less than 1 day: hrs. mins.

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

9 BIRTHPLACE (State or country) Brownsville, Tenn

PARENTS

10 NAME OF FATHER: John B. Ashe.
11 BIRTHPLACE OF FATHER (State or country): N. C.
12 MAIDEN NAME OF MOTHER: Eliza Hay
13 BIRTHPLACE OF MOTHER (State or country): N. C.

14 THE ABOVE IS TRUE
(Informant) John, B. Ashe.
(Address) 1918 McKinney Ave.

15 Filed 4/29/19 191 John M. Holt Registrar

MEDICAL PARTICULARS

16 DATE OF DEATH April. 29. 1919.
(Month) (Day) 191 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 18, 19 19, to Apr 29, 19 19
that I last saw h. alive on Apr 28, 19 19
and that death occurred, on the date stated above, at 6-15 m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
Contributory (Secondary) Cerebral Pneumonia
(duration) 2 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature] M. D.
Apr 29, 19 19 (Address) 817 Louisiana

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for State Statutes.)

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Glenwood Cemetery	4/30/19 191
20 UNDERTAKER	ADDRESS
Settegast-Kopf Co	

479-219-100M

NOTE WELL—INSTRUCTIONS ON THE REVERSE SIDE.
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

Where Stillborn is given as cause of Death, file birth certificate. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

154

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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.

1 PLACE OF DEATH

County Jackson

Township Blue or Village ..... or City [illegible] (No. 15th & Arlington St.; Ward)

Registration District No. 398 File No. 1397

Primary Registration District No. 5554 Registered No. 7

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

2 FULL NAME Robert Thompson Van-Horn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6 DATE OF BIRTH May (Month) 19th (Day) 1824 (Year)

7 AGE 91 yrs. 7 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) East Mahoning Penn.

PARENTS

10 NAME OF FATHER: Henry Van-Horn

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Penn.

12 MAIDEN NAME OF MOTHER: Elizabeth Thompson

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Adela Van-Horn

(Address) 15th Arlington

15

Filed Jan. 5 1916. F. L. Cook Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 3rd (Day) 1916 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 23 1915, to Jan. 3rd 1916, that I last saw him alive on Jan. 2nd 1916, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Senility

162

154

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

CONTRIBUTORY (Secondary)

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

(Signed) Wm L. Gilmore M. D.

Jan 3rd 1916 (Address) N Washington

*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 this State 60 yrs. 6 mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Washington

DATE OF BURIAL 1/5 1916

20 UNDERTAKER Stine & McClure Und Co.

ADDRESS 724 Oak St KC

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.

1PLACE OF DEATH

TEXAS STATE BOARD OF HEALTH
Bureau of Vital Statistics

1072-615-25M

STANDARD CERTIFICATE OF DEATH

Registered No. 5813

County Bexar

City San Antonio (No. 221 Mayencak St.; Ward)

[If death occurred in hospital or institution give its NAME instead of street and number.]

2FULL NAME George Wythe Baylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (Write the word)
Male	White	Widowed

6 DATE OF BIRTH: Aug (Month) 24 (Day) 1832 (Year)

7 AGE: 83 yrs. 7 mos. 3 ds.
If less than 2 years state; If breast fed yes ..... No ..... | If less than 1 day ..... hrs. ..... mins.

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

9 BIRTHPLACE (State or country): Fort Sill Oklahoma

PARENTS

10 NAME OF FATHER: John W Baylor

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Sophia E Weidner

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mary C Baylor
(Address) San Antonio Texas

15 Filed 3/27 191 6 Registrar

MEDICAL PARTICULARS

16 DATE OF DEATH: Mar (Month) 27 (Day) 1916 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1914, to Mar 26, 1916, that I last saw h living alive on Mar 26 1916, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Senility 154

(Duration ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Extravasation

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P Leonard Nixon M. D.

3/27 1916 (Address) San Antonio Tex

*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. 4 mos. ..... ds. In the State 74 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? San Antonio Texas
Former or usual residence " " "

19 PLACE OF BURIAL OR REMOVAL: Confederate Cemetery
DATE OF BURIAL: Mar 28 1916

20 UNDERTAKER: Sloan & Hagen
ADDRESS: San Antonio

19

7757

3061

12078

CERTIFICATE OF DEATH—PHYSICIAN'S FORM

UNDERTAKER'S

CERTIFICATE AND RECORD OF DEATH

OF

REGISTERED NO. 7757

DEPARTMENT OF HEALTH

CITY OF CHICAGO

PERSONAL AND STATISTICAL PARTICULARS

1. FULL NAME Augustus Louis Chetlain
2. (a) SEX M (b) COLOR W (c) SINGLE, MARRIED, WIDOWED, DIVORCED Married (write in)
3. (a) BIRTHPLACE St Louis Mo (state or country) (b) DATE OF BIRTH Dec 26-1824
4. AGE 89 YEARS 2 MONTHS 17 DAYS ___ HOURS (if less than one day old)
5. DIED ON THE 15 DAY OF March 1914 AT ABOUT 8 P. M.
6. LAST OCCUPATION (a) Banker (profession, trade or kind of work) (b) ___ (industry or business)
   FROM THE YEAR (c) 1896 TO THE YEAR 1914
7. FORMER OCCUPATION (a) ___ (b) ___
   FROM THE YEAR (c) ___ TO THE YEAR ___
8. (a) PLACE OF DEATH 7414 Sheridan Road (street and no.) (b) HOW LONG AT PLACE OF DEATH 20 years
9. (a) USUAL RESIDENCE Same (b) WARD 25th
10. HOW LONG RESIDENT IN CITY 48 years
11. HOW LONG IN STATE 89 years
12. HOW LONG IN U.S. IF FOREIGN BORN Same
13. (a) NAME OF FATHER Louis Chetlain
    (b) BIRTHPLACE OF FATHER Bern Switzerland (state or country)
14. (a) MAIDEN NAME OF MOTHER Julia Droz
    (b) BIRTHPLACE OF MOTHER Switzerland (state or country)

The foregoing stated personal particulars are true to the best of my knowledge and belief.

15. INFORMANT [illegible signature]
    ADDRESS 7414 Sheridan Road

16. PLACE OF BURIAL Galena, Illinois
    DATE OF BURIAL March 17-1914
    HOUR 2 P.M.
17. UNDERTAKER P Wernerschfinch
    ADDRESS 7066 N Clark St
    LICENSE 399
    TELEPHONE 134 R.P.

PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH

I Hereby Certify THAT I ATTENDED DECEASED FROM Oct 1913 TO Mch 15 1914 THAT I LAST SAW him ALIVE ON THE 15 DAY OF March 1914 THAT he DIED ON THE DAY AND AT ABOUT THE HOUR STATED ABOVE, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE CAUSE OF his DEATH WAS AS HEREUNDER WRITTEN.

(IF UNDER ONE YEAR OLD, STATE HOW FED)

		DURATION* in years, months, days or hours
(a) CAUSE OF DEATH	Exhaustion Senility	1 year
(b) CONTRIBUTORY (SECONDARY)	Chronic Organic Heart	years

*Of each Cause according to the Clinical History

Witness my hand This 16 DAY OF March 1914

(SIGNATURE) Paul Hullforth M.D.

ADDRESS 696 No Ashland a TELEPHONE RPX

FILED

306

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.

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

417

1 PLACE OF DEATH

County Rutherford

Civil Dist. 3rd. or Village Smyrna or City ________ (No. ______, __________ St.; ______ Ward)

Registration District No. 761 File No. ______

Primary Registration District No. 3 Registered No. 42

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

2 FULL NAME Col. John S Gooch

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Male — 4 COLOR OR RACE: White — 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): ______	16 DATE OF DEATH: Dec. (Month) 23 (Day), 1915 (Year)
6 DATE OF BIRTH: June (Month) 7 (Day), 1842 (Year)	17 I HEREBY CERTIFY, That I attended deceased from Nov 1915, to Dec 23, 1915, that I last saw him alive on Dec 23, 1915, and that death occurred, on the date stated above, at 9 P m.
7 AGE: ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ______ hrs. or ______ min.?	The CAUSE OF DEATH* was as follows: [illegible] — arterio sclerosis (Duration) ______ yrs. ______ mos. ______ ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work: Farming [illegible] (b) General nature of industry, business, or establishment in which employed (or employer): ______	Contributory (SECONDARY) ______ (Duration) ______ yrs. ______ mos. ______ ds.
9 BIRTHPLACE (State or country): Rutherford Co Tenn	(Signed) J S Lowry, M. D. Dec 24, 1915 (Address) Smyrna Tenn
PARENTS — 10 NAME OF FATHER: John Cleborn Gooch	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
11 BIRTHPLACE OF FATHER (State or country): Tenn	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ______ yrs. ______ mos. ______ ds. In the State ______ yrs. ______ mos. ______ ds.
12 MAIDEN NAME OF MOTHER: Sanders	Where was disease contracted, if not at place of death? ______ Former or usual residence ______
13 BIRTHPLACE OF MOTHER (State or country): Tenn	19 PLACE OF BURIAL OR REMOVAL: Cannon Cemetery — DATE OF BURIAL: Dec. 25, 1915
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) H. J. Lowry (Address) ______	20 UNDERTAKER: W. H. King — ADDRESS: Smyrna
15 Filed 12/24, 1915 E. O. Jenkins, REGISTRAR	

Form V. S. No. 1 - 1913.

Coroner

16112

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

1 PLACE OF DEATH

County Jefferson

Registration District No. 51

Vol. P...

Primary Registration District No. 2275

Inc. Town ...

File No. ...

Registered No. 2071

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

2 FULL NAME John W. Green

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: male. 4 COLOR OR RACE: White. 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	16 DATE OF DEATH: June 13, 1920 (Month) (Day) (Year)
6 DATE OF BIRTH: Oct. 8, 1841 (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended deceased from ..., 191.., to ..., 191.., that I last saw h... alive on ..., 191.., and that death occurred on the date stated above at 10 A.m. The CAUSE OF DEATH* was as follows:
7 AGE: 78 yrs. 8 mos. 5 ds. IF LESS than 1 day ... hrs. or ... min.?	Gun shot of Wound of Head ... Deceased
8 OCCUPATION (a) Trade, profession, or particular kind of work: Stock + Bond. (b) General nature of industry, business or establishment in which employed (or employer): Broker	(Duration) ... yrs. ... mos. ... ds.
9 BIRTHPLACE (State or country): Louisville, Ky.	Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.
PARENTS — 10 NAME OF FATHER: Hestor Green	ROY L. CARTER, M.D. (Signed) ...
11 BIRTHPLACE OF FATHER (State or country): Virginia	June 14, 1920 (Address) Theo. W. Danger
12 MAIDEN NAME OF MOTHER: Ellinor Ruggles	*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 3 1/2 hours ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
13 BIRTHPLACE OF MOTHER (State or country): ...	Where was disease contracted, if not at place of death? ...
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Winnifred Green	Former or usual residence 1408 - S. 3rd street
(Address) 713 - S. 3rd	19 PLACE OF BURIAL OR REMOVAL: Cave Hill. DATE OF BURIAL: June 14, 1920
15 Filed JUN 14 1920, 191.. ... Registrar	20 UNDERTAKER: Lee E. Cralle. ADDRESS: 600 W. Chestnut

11—8194

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.

STATE OF OHIO
DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Hamilton Registration District No. 198 File No.
Township Loveland O. Primary Registration District No. 2192 Registered No.
or Village No. St. Ward
or City of (If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Brigden Thomas T. Heath Did Deceased Serve in U. S. Navy or Army Civil.

(a) Residence. No. St. Ward
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed or Divorced (write the word): Divorced
6a If married, widowed or divorced — HUSBAND of (or) WIFE of: Mary L. Slack
6 DATE OF BIRTH (month, day, and year): May 10
7 AGE — Years: 90. Months: 7. Days: 8. If LESS than 1 day hrs. min.
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired General.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town): Xenia
(State or country): Ohio

PARENTS
10 NAME OF FATHER: Uriah Heath
11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown.
12 MAIDEN NAME OF MOTHER: Mary Ann Perkins
13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unknown.

14 Informant: Mr. Herman Ferris
(Address): Loveland R.F.D.
15 Filed 10/20, 1925 W. H. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 18 1925
17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1925, to Oct 18, 1925
that I last saw him alive on Oct 17, 1925
and that death occurred, on the date stated above, at 8 30 a.m.
The CAUSE OF DEATH* was as follows:
Acute Bronchitis
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) 3 yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. O. Ferris M. D.
(Address) Loveland O.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Sterling Grove Cem.
DATE OF BURIAL: Oct 20 25
20 UNDERTAKER License No. 1334
Address: Loveland O.
E. A. Trefz.

of OCCUPATION is very important. See instructions on back of certificate.