

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.

STATE OF ARKANSAS
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

1328

1 PLACE OF DEATH
 County Van Buren
 Township Bradley
 Inc. Town _____
 City Bee Branch
 Registration District No. 628 File No. _____
 Primary Registration District No. 6723 Registered No. _____
 (No. _____ St.; _____ Ward)
 2 FULL NAME William Glenn French
 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 married
 (Write the word)
 6. DATE OF BIRTH 8th 12 1900
 Month Day Year
 7. AGE 24 yrs. 1 mos. 22 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) Arkansas
 PARENTS
 10. NAME OF FATHER Geo. H. French
 11. BIRTHPLACE OF FATHER (State or Country) Tennessee
 12. MAIDEN NAME OF MOTHER Mattie Moore
 13. BIRTHPLACE OF MOTHER (State or Country) Tennessee
 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Thos. G. French
 (Address) Bee Branch
 15. Filed _____ 19 _____ G. C. Hedger
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 7 1924
 Month Day Year
 17. I HEREBY CERTIFY That I attended the deceased from _____, 19 _____, to _____, 19 _____, that I last saw h. _____ alive on _____, 19 _____, and that death occurred on the date stated above, at _____ m.
 The CAUSE OF DEATH * was as follows:
Myocardial Infarction
 Duration _____ yrs. _____ mos. _____ ds.
 Contributory _____
 SECONDARY _____
 Duration _____ yrs. _____ mos. _____ ds.
 Signed T. B. H. W. H. M. D.
 _____, 191 _____ Address Demas
 *State the DISEASE CAUSING DEATH, or, in death 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 Bee Branch DATE OF REMOVAL _____, 19 _____
 20. UNDERTAKER _____ ADDRESS _____