

STATE OF OHIO
 DEPARTMENT OF HEALTH
 DIVISION OF VITAL STATISTICS
 8118 CERTIFICATE OF DEATH

129-90

1 PLACE OF DEATH
 County Cuyahoga Registration District No. _____ File No. 48254
 Township _____ Primary Registration District No. _____ Registered No. 7116
 or Village _____ No. _____ Hollenden Hotel St., 2 Ward
 or City of Cleveland (If death occurred in a hospital or institution, give its NAME instead of street and number)
 2 FULL NAME Jay C. Budd Did Deceased Serve in U. S. Navy or Army 2
 (a) Residence No. Hollenden Hotel St., _____ Ward. (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) Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1865

7 AGE Years Months Days If LESS than 1 day hrs. or min.
58 8 18

8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Bookkeeper
 (b) General nature of Industry, business, or establishment in which employed (or employer)
 (c) Name of employer Messrs. Budd

9 BIRTHPLACE (city or town) Grater Ohio
 (State or country)

10 NAME OF FATHER Geo A Budd

11 BIRTHPLACE OF FATHER (city or town) Grater Ohio
 (State or country)

12 MAIDEN NAME OF MOTHER Emmie Minnie

13 BIRTHPLACE OF MOTHER (city or town) Waver Ohio
 (State or country)

14 Informant George Budd
 (Address) Franklin Ky

15 Filled _____ 19 _____
AUG 24 1923 RJ Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:
Found dead at his room
Hollenden Hotel died
sudden chronic Endo
carditis. Myocarditis
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY chronic Rheumatism
 (duration) _____ yrs. mos. ds.

18 Where was disease contracted if not at place of death? now known

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Histology, Exam.
 (Signed) R. S. Hammond M. D.
Aug 24 1923 (Address) 20 Wayne

*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 Clyra Ohio DATE OF BURIAL 8 25 1923

20 UNDERTAKER, License No. _____ ADDRESS The Jennings Co
1834 E 55
CA Pratt

of information should be carefully supplied. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.