

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.

1 PLACE OF DEATH

County PutnamCivil Dist. 194

OR

Village

OR

City

Registration District No.

Primary Registration District No.

(No.

St.

Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

31293

File No. 26

Registered No.

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

2 FULL NAME

George Oscar Davis

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 7 17 1904
(Month) (Day) (Year)

7 AGE 24 yrs. 3 mos. 27 ds. IF LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(1) Trade, profession or particular kind of work Farmer
(2) General nature of industry, business or establishment in which employed (as employee)

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER John Byrd Davis

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Minna Elvira Hudson

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Initialed) Byrd Davis
(Address) Butler Tenn

15 Filed 51 L. M. Huddleston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 14 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10-21 1928 to 11-14 1928
that I last saw him alive on 11-13 1928

and that death occurred, on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows: meningitis

[Duration] yrs. mos. ds.

Contributory otitis media
(SECONDARY) [Duration] yrs. mos. ds.

Signed J. G. Butler M. D.
10-14 1928 Address Elgood Tenn

* 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 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 DATE OF BURIAL

20 UNDERTAKER ADDRESS