

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.

1 PLACE OF DEATH

County Putnam
 Civil Dist. 19
 or
 Village
 or
 City Algood (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

31282

CERTIFICATE OF DEATH

Registration District No. 796
 Primary Registration District No. 475-19

File No. 27

Registered No. _____

(If death occurred in a hospital or institution, give its NAME, its full street and number.)

2 FULL NAME Mrs. Margaret G. Gilder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 MARRIAGE STATUS widowed
(Write the word)

6 DATE OF BIRTH Nov 13 1846
(Month) (Day) (Year)

7 AGE 81 yrs. 7 mos. 19 da. If LESS than 1 day, hrs. or min.?
 8 OCCUPATION Housekeeper

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER W. A. Gilder
 11 BIRTHPLACE OF FATHER (State or country) Tenn
 12 MAIDEN NAME OF MOTHER Not known
 13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) M. G. Gilder
 (Address) Algood

15 Registrar L. M. Huddleston

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1927 to Mar 23 1928
 that I last saw her alive on Mar 23 1928
 and that death occurred, on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Aprophelia (Byraligid)
 (Duration) 10 mos. da.

Contributory (Secondary) _____
 (Duration) _____ yrs. mos. da.
 Signed J. P. Moore M. D.
Oct 2 1928 Address Algood

* 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 NEARBY RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ da. In the State _____ yrs. _____ mos. _____ da.
 Where was disease contracted, if not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1928

20 UNDERTAKER _____ ADDRESS _____