

WRITE PLAINLY, WITH INK AND 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 Jackson  
Civil Dist. 11  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. XXXX11  
Primary Registration District No. 11

File No. 996

Registered No. \_\_\_\_\_

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

2 FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>1</u> / <u>6</u> / <u>1917</u> (Month) (Day) (Year)		
7 AGE _____ yrs. _____ mos. <u>1</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
9 BIRTHPLACE (State or country) <u>Tenn.</u>		
PARENTS	10 NAME OF FATHER <u>John Baptist</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Tenn.</u>	
	12 MAIDEN NAME OF MOTHER <u>Diana Howell</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Tenn.</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
1 / 7 / 1917  
(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 \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
no apparent cause. Person was poorly developed 160

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) L. R. Anderson, M. D.  
3/5 / 1917 (Address) Gainesboro

\*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 \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Baptist  
(Address) Gainesboro R.H.

15 Filled 3/5 / 1917 by L. R. Anderson  
REGISTRAR

19 PLACE OF BURIAL OR REMOVAL <u>New Salem Cem.</u>	DATE OF BURIAL <u>1</u> / <u>8</u> / <u>1917</u>
20 UNDERTAKER <u>Matt Baptist</u>	ADDRESS <u>Gainesboro</u>