

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

1 PLACE OF DEATH
 County Jackson
 Civil Dist. First Registration District No. 441 File No. 932
 or Village Gainesboro Primary Registration District No. _____ Registered No. _____
 or City _____ (No. _____, _____ St.; _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thornice Scott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 (Write the word)

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION House wife
 (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) Gainesboro Tenn

PARENTS

10 NAME OF FATHER David Hummel

11 BIRTHPLACE OF FATHER (State or country) Gainesboro Tenn

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Brook Elkins
 (Address) Gainesboro

15 Filed Feb 9 7 1917 W. L. Little
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 19th 1917
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1916, to Jan 1917, that I last saw her alive on Jan 18, 1917, and that death occurred, on the date stated above, at 4 a.m.
 The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
 (SECONDARY) _____
 (Signed) Chas C. Fowler M. D.
 _____, 191____ (Address) _____

*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 Fowler Cemetery DATE OF BURIAL Jan 20, 1917
 20 UNDERTAKER McLannan & Stapp ADDRESS Gainesboro