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. Sixth or Village Gilkam or City ......(No. ......, ...St.; ......Ward)

Registration District No. 442 — File No. 227

Primary Registration District No. ...... — Registered No. 3

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

2 FULL NAME Sarah Wright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Divorced

6 DATE OF BIRTH: 1 (Month) 23 (Day), 1878 (Year)

7 AGE: 38 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or ......min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Tennessee

PARENTS

10 NAME OF FATHER: Thomas Wright

11 BIRTHPLACE OF FATHER (State or country): Tennessee

12 MAIDEN NAME OF MOTHER: Susan Murphy

13 BIRTHPLACE OF MOTHER (State or country): Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Wright

(Address)

15

Filed Jan 23, 1917 A J Harris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 (Month) 20 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1-11 1917, to 1-20, 1917, that I last saw her alive on 1-20, 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

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

Contributory (SECONDARY)

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

(Signed) W. M. Brown, M. D.

1-20, 1917 (Address) Gilkam, 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: New Hope — DATE OF BURIAL: Jan 20, 1917

20 UNDERTAKER: D. T. Taylor — ADDRESS: Gainesboro

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