

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 Jackson
 Civil Dist. 6 & 9
 or
 Village _____
 or
 City _____ (No. _____, _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 442 File No. _____
 Primary Registration District No. _____ Registered No. 9

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

2 FULL NAME Sarah Mabrey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED 8
Write the word

6 DATE OF BIRTH April 20, 1895
(Month) (Day) (Year)

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

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) _____

PARENTS
 10 NAME OF FATHER Boesed Mabrey
 11 BIRTHPLACE OF FATHER (State or country) Gainesboro
 12 MAIDEN NAME OF MOTHER Bessie Brown
 13 BIRTHPLACE OF MOTHER (State or country) Gainesboro

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Asa Lynn
 (Address) Gainesboro

15 Filed April 16, 1917 A. J. Pharris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 15, 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 medical aid or attendance
A. J. Pharris, M. D.
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____, 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 Waverly DATE OF BURIAL April 16, 1917
 20 UNDERTAKER Asa Lynn ADDRESS Gainesboro