

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. 679
 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

Primary Registration District No. _____

File No. 240

Registered No. 5

(If death occurred in hospital or in home, give its NAME of street and number)

2 FULL NAME Martha Anderson

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH December 4, 1923
(Month) (Day) (Year)

7 AGE 74 2 5
yrs. mos. ds. If LESS than 1 day, ----hrs. or ----min.?

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

9 BIRTHPLACE (State or country) Tennessee

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Wylie Anderson
 (Address) Tennessee

15
 Filed Feb 10, 1917 A. J. Pharris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 9, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1917, to Jan 28, 1917, that I last saw him alive on January 28, 1917, and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH * was as follows: Lung

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

Contributory _____
(SECONDARY) (Duration) ----yrs. ----mos. ----ds.

(Signed) A. J. Pharris, M. D.
Feb 10, 1917 (Address) Tennessee

*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 Anderson Cemetery DATE OF BURIAL _____, 1917

20 UNDERTAKER Wylie Anderson ADDRESS Tennessee