

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1 PLACE OF DEATH 3242 STATE OF TENNESSEE  
 County Jackson STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 Civil Dist. 489 Registration District No. 442 File No. 271  
 or Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. 7  
 or City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Still Borne Talon

**PERSONAL AND STATISTICAL PARTICULARS**

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

6 DATE OF BIRTH April 11, 1917  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
\_\_\_\_\_ yrs. \_\_\_\_\_ 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) Gainesboro

PARENTS

10 NAME OF FATHER Charley Taylor

11 BIRTHPLACE OF FATHER (State or country) Gainesboro

12 MAIDEN NAME OF MOTHER Southern Carhide

13 BIRTHPLACE OF MOTHER (State or country) Gainesboro

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Charley Fowler  
(Address) Gainesboro

15 Filed April 12, 1917 A. J. Pharris REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH April 11, 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:  
Still borne

Contributory \_\_\_\_\_ (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) A. J. Pharris Reg. 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 Westhope cemetery DATE OF BURIAL April 12, 1917

20 UNDERTAKER Ad Talon ADDRESS Gainesboro