STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

283

1 PLACE OF DEATH
County Jackson
Civil Dist. 1st or Village Gainesboro or City _____ (No. _____, _____ St.; _____ Ward)
Registration District No. 441
Primary Registration District No. 2-4401
File No. 16
Registered No. _____
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lora Tubville

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.*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Maried
6 DATE OF BIRTH: Jan (Month) 10 (Day), 1846 (Year)
7 AGE: 71 yrs. ____ mos. ____ ds.
If LESS than 1 day, ____ hrs. or ____ min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): ____
9 BIRTHPLACE (State or country): Jackson Co.

PARENTS
10 NAME OF FATHER: John Odom
11 BIRTHPLACE OF FATHER (State or country): Jackson Co
12 MAIDEN NAME OF MOTHER: Margret Smith
13 BIRTHPLACE OF MOTHER (State or country): Jackson Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tate Tubville
(Address) Ind

15 Filed July 2, 1917 W H Hill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 1 (Day), 1917 (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:
Hemorrhage of the Lungs
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. M. McLean, 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: Mt Magnet Yard
DATE OF BURIAL: June 2, 1917

20 UNDERTAKER
ADDRESS

Form V. S. No. 4—25M. FOSTER & PARKER CO., NASHVILLE