STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

300

1 PLACE OF DEATH

County Jackson

Civil Dist. 1

or

Village _____ Registration District No. 441 File No. 15

or

City _____ (No. _____, _____ St.; _____ Ward) Primary Registration District No. 24401 Registered No. _____

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

2 FULL NAME Mildred May Washington

MARGIN RESERVED FOR BINDING

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: Black

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

6 DATE OF BIRTH: July (Month) 16 (Day), 1917 (Year)

7 AGE: ____ yrs. 4 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work: X

(b) General nature of industry, business, or establishment in which employed (or employer): X

9 BIRTHPLACE (State or country): Jackson Co.

PARENTS

10 NAME OF FATHER: Daniel Washington

11 BIRTHPLACE OF FATHER (State or country): Sumner Co.

12 MAIDEN NAME OF MOTHER: Vernie Harris

13 BIRTHPLACE OF MOTHER (State or country): Jackson Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Washington

(Address) Gainesboro, Tenn

15 Filed June 28 1917 W. H. Settle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 21 (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: Dr

I saw the baby some time after death occured and do not know Cause.

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

Contributory (SECONDARY) _____

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

(Signed) Chas P. Fowlkes, M. D.

_____, 191__ (Address) Gainesboro 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: Brooks Grave yard

DATE OF BURIAL: June 22, 1917

20 UNDERTAKER: None.

ADDRESS: _____

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