

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.

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Jaerson
Civil Dist. 1 or Village _____ or City _____ (No. _____, St.; _____ Ward)
Registration District No. 441 File No. 302 19
Primary Registration District No. 24401 Registered No. _____
2 FULL NAME Allie (Still) Bani
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
6 DATE OF BIRTH June 21, 1917
7 AGE Still born 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) _____
9 BIRTHPLACE (State or country) Jaerson Co.
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (State or country) X
12 MAIDEN NAME OF MOTHER Amanda Allie
13 BIRTHPLACE OF MOTHER (State or country) Jaerson Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____
15 Filed June 27, 1917 W. N. Settle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 21, 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:

(This child was still born)

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) N. M. McLean, M. D. Bainbridge
_____, 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 Same yard DATE OF BURIAL June 22, 1917
20 UNDERTAKER none ADDRESS X