

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		STATE OF TENNESSEE	
County <u>Jackson</u>		STATE BOARD OF HEALTH Bureau of Vital Statistics	
Civil Dist. <u>#12</u>		CERTIFICATE OF DEATH	
or Village		Registration District No. <u>44412</u>	File No. <u>14</u>
City <u>Bloomington</u> (No. <u>375</u>)		Primary Registration District No. <u>12</u>	Registered No. <u>14</u>
2 FULL NAME <u>Stillborn Johnson</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> <small>(Write the word)</small>	16 DATE OF DEATH <u>Aug. 7, 1917</u> <small>(Month) (Day) (Year)</small>
6 DATE OF BIRTH <u>Aug 7, 1917</u> <small>(Month) (Day) (Year)</small>		17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 7, 1917</u> , to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at <u>11</u> m. The CAUSE OF DEATH* was as follows: <u>Stillborn</u>	
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?		Contributory (SECONDARY) _____ (Duration) _____ 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) _____		(Signed) <u>J. M. White</u> , M. D. <u>8-7, 1917</u> (Address) <u>Bloomington</u>	
9 BIRTHPLACE (State or country) <u>Jackson Co</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
PARENTS	10 NAME OF FATHER <u>Bob Johnson</u>	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 _____	
	11 BIRTHPLACE OF FATHER (State or country) <u>Pottsville</u>	19 PLACE OF BURIAL OR REMOVAL <u>Philadelphia</u>	
	12 MAIDEN NAME OF MOTHER <u>B. A. Jackson</u>	DATE OF BURIAL <u>8-7-1917</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>Jackson Co</u>		20. UNDERTAKER <u>None in charge</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Bob Johnson</u> (Address) <u>Bloomington</u>		ADDRESS _____	
15 Filed <u>Aug 11, 1917</u> <u>J. B. Billingsley</u> REGISTRAR <u>Gardner</u>			