STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

227

1 PLACE OF DEATH

County Jackson

Civil Dist. 12

or Village Mayfield

or City _____ (No. _____, St.; _____ Ward)

Registration District No. 4412 File No. 16

Primary Registration District No. 12 Registered No. 16

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

2 FULL NAME Hazel Lee Riley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Sept (Month) 23 (Day), 1913 (Year)

7 AGE: 3 yrs. 11 mos. 20 ds. If LESS than 1 day, ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Jackson Co Tenn

PARENTS

10 NAME OF FATHER: Woody Riley

11 BIRTHPLACE OF FATHER (State or country): Jackson Co Tenn

12 MAIDEN NAME OF MOTHER: Belle Start

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N M McCain
(Address) Gamebaro Tenn R #3

15 Filed Sept 15, 1917 Jno B Billingsley REGISTRAR
Gamebaro Tenn R #3

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 13 (Day), 1917 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 1917, to Sept 13, 1917, that I last saw her alive on Sept 13, 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:
acute Bronchitis Fla

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

Contributory (SECONDARY)

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

(Signed) N M McCain, M. D.
Sept 15, 1917 (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: Stafford Cemetery
DATE OF BURIAL: Sept 14, 1917

20 UNDERTAKER: M Billingsley
ADDRESS: Gamebaro Tenn R #3

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.

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