

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state 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

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1 PLACE OF DEATH
 County Jackson
 Civil Dist. H H
 or
 Village _____
 or
 City _____ (No. _____) St.; _____ Ward _____

Registration District No. 44404 File No. _____
 Primary Registration District No. _____ Registered No. 10
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Eliza P. Wells

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
Write the word

6 DATE OF BIRTH July 18, 1861
(Month) (Day) (Year)

7 AGE 56 yrs. 2 mos. 11 ds. If LESS than 1 day, ---- hrs. or ---- min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Ky

PARENTS

10 NAME OF FATHER Wash Wells

11 BIRTHPLACE OF FATHER (State or country) Ky

12 MAIDEN NAME OF MOTHER Martha Bell

13 BIRTHPLACE OF MOTHER (State or country) not known

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 29, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1917, to Sept 29, 1917, that I last saw her alive on Sept 29, 1917, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) _____ yrs. _____ mos. 23 ds.

Contributory (SECONDARY) Endocarditis, acute

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. B. Clark M. D.
Sept 30, 1917 (Address) Haydenburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Vera Clark
 (Address) Red Bank Springs

15 Filed 9-30-17 1917 F. B. Clark REGISTRAR

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 Menches Graveyard DATE OF BURIAL 9-30, 1917

20 UNDERTAKER Jon Will ADDRESS Willetts