

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

County Jackson

Civil Dist. #10 Registration District No. 1444 File No. 14

or Village _____ Primary Registration District No. 10 Registered No. 14

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

2 FULL NAME Emiliea Bean

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

STATE OF TENNESSEE
STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow

(Write the word)

6 DATE OF BIRTH Aug - 25 - 1834

(Month) (Day) (Year)

7 AGE 83 yrs. 1 mos. 17 ds.

IF LESS than 1 day, --- hrs. or --- min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Housekeeping

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

9 BIRTHPLACE (State or country) Rhea Co. Tenn

10 NAME OF FATHER James Stults

11 BIRTHPLACE OF FATHER (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (State or country) North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. B. Burris

(Address) Cookville Tenn #5

15 Filed Nov 3 - 1917 J. H. Cummings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct - 11 - 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:

Influenza

No Physician attended

(Duration) --- yrs. --- mos. --- ds.

Contributory Old age & Genl debility

(SECONDARY) (Duration) --- yrs. --- mos. --- ds.

(Signed) X, M. D.

_____, 191____ (Address) X

*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 Magness Graveyard DATE OF BURIAL Oct - 15 - 1917

20 UNDERTAKER No Undertaker ADDRESS _____