

WITH PLAINTEXT WITH UNIFORMS...
 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

345

1 PLACE OF DEATH
 County Jackson
 Civil Dist. 11 Registration District No. 44411 File No. _____
 or Village _____ Primary Registration District No. 11 Registered No. _____
 or City _____ (No. _____, St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 10 21 1917
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, -----hrs. or -----min.?

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

9 BIRTHPLACE (State or country) Tenn.

PARENTS

10 NAME OF FATHER Frank Lawson

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Carter

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Frank Lawson
 (Address) Hainabers P.H. 3.

15 Filed 11/9, 1917 L. P. Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 23, 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:
Stillborn

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

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

(Signed) L. P. Anderson, M. D.
10/23, 1917. (Address) Hainabers 9

*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 Fugate Cemetery DATE OF BURIAL 10/24, 1917

20 UNDERTAKER Jim Lawson ADDRESS Hainabers