STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

350

1 PLACE OF DEATH

County Jackson

Civil Dist. 1

or Village

or City Gainesboro (No. ____, ____ St.; ____ Ward)

Registration District No. 44 1 — File No. 1

Primary Registration District No. 2 44 a 1 — Registered No. ____

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

2 FULL NAME Mary Ellen Porter

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH April (Month) 24 (Day), 1844 (Year)

7 AGE 73 yrs. 5 mos. 28 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

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

9 BIRTHPLACE (State or country) Kentucky

PARENTS

10 NAME OF FATHER: Dan Porter

11 BIRTHPLACE OF FATHER (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Nancy Sprowls

13 BIRTHPLACE OF MOTHER (State or country): Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(Address) ____

15 Filed Jan 25 191[illegible] W. H. Settle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. ~~Dec~~ 14 (Month) (Day), 1917 (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: 1 1 7

Abscess of bowels and Heart failure

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

Contributory (SECONDARY) ____

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

(Signed) Dr. H. M. McCoin, M. D.

191__ (Address) Gainesboro Tn

*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: Nov. 15, 1917

20 UNDERTAKER — ADDRESS

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.