# STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

273

1 PLACE OF DEATH

County Jackson

Civil Dist. 3 or Village or City Granville

Registration District No. 44405

Primary Registration District No. 5

File No. 15

Registered No.

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

(No. ____, ____ St.; ____ Ward)

2 FULL NAME Elizabeth Collier

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.

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: ____ (Month) ____ (Day), 1____ (Year)

7 AGE: 74 yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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

9 BIRTHPLACE (State or country): Granville

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Granville

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): ——

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will Hall
(Address) Granville

15
Filed Jan 11, 1918 W. R. Hall
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 21 (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:

Heart failure & old age
Had no Dr.

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

Contributory (SECONDARY)

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

(Signed) ____, M. D.

____, 191__ (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: Hillsboro Cem'y
DATE OF BURIAL: Dec 24, 1917

20 UNDERTAKER: Williamson
ADDRESS: Granville

Form V.S. No. 1—100M. FOSTER & PARRAN CO., NASHVILLE