

WRITE PLAIN 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. 11
or
Village _____
or
City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

20

Registration District No. 444 11

File No. _____

Primary Registration District No. 11

Registered No. 3

2 FULL NAME

Willard L. Royland

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

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 7 6 1918
(Month) (Day) (Year)

7 AGE 1 yrs. 6 mos. 26 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION Infant
(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 Thomas Royland
11 BIRTHPLACE OF FATHER (State or country) Tenn
12 MAIDEN NAME OF MOTHER Fannie Hopkins
13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Royland
(Address) Gambrobes R#3

15 Filed 3/18/1918 L R Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 2 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1/31 1918, to 2/2 1918, that I last saw him alive on 2/2 1918, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:
Infectious Diarrhoea
113
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L R Anderson, M. D.
2/3 1918 (Address) Gambrobes CH#

*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 Haile Cem. DATE OF BURIAL 2/4 1918

20 UNDERTAKER Wm. Norton ADDRESS Gambrobes Pky