

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.

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

86

1 PLACE OF DEATH
County Jackson
Civil Dist. A 4 Registration District No. 44404 File No. _____
or _____ Primary Registration District No. _____ Registered No. 10
Village _____
or _____
City _____ (No. _____, _____ St.; _____ Ward)
2 FULL NAME Wald Johnson
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____, 1908
(Month) (Day) (Year)

7 AGE 8 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) Clay Co Tenn

PARENTS

10 NAME OF FATHER Walter Johnson

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Etta B Bailey

13 BIRTHPLACE OF MOTHER (State or country) Tenn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 17 1918, to July 22, 1918, that I last saw her alive on July 20, 1918, and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH * was as follows:
Shig Typhoid fever
_____ lat _____
_____ (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) Frank B Clark, M. D.
Aug 9, 1918. (Address) Haydenburg

*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 _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Bailey
(Address) Whitneyville Tenn

15
Filed Sept 6, 1918 Pat Clark
REGISTRAR

18 PLACE OF BURIAL OR REMOVAL Reeling Ground **DATE OF BURIAL** July 25, 1918

20 UNDERTAKER H. C. Cherry **ADDRESS** Oct, Whitneyville