

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.

1 PLACE OF DEATH

County Jackson
 Civil Dist. 14
 or
 Village _____
 or
 City _____ (No. _____, _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

131

Registration District No. 4414 File No. _____
 Primary Registration District No. _____ Registered No. 3
 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Nettie Thomas

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 September 22, 1902
(Month) (Day) (Year)

7 AGE 16 yrs. 28 mos. 28 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER Yerris Thomas

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Wice Kemp

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Missie Butler
 (Address) Defeated, Tenn.

15 Filed Oct 20, 1918 C. C. Carter
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 20, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____, 191____,
 that I last saw her alive on Oct 18, 1918,
 and that death occurred, on the date stated above, at 3⁰⁰ p.m.
 The CAUSE OF DEATH* was as follows:

Influenza following Typhoid fever
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Chas Robinson, M. D.
 _____, 191____ (Address) Defeated, Tenn.

*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 _____ DATE OF BURIAL October 1918

20 UNDERTAKER None ADDRESS _____