

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

182

1 PLACE OF DEATH  
County Jackson  
Civil Dist. # 7 or Village \_\_\_\_\_  
Registration District No. 44407  
or Primary Registration District No. 44407 Registered No. 4  
City Blossington Sp. R. # St.; \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thomas Lee Vannie Jackson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 8, 1889  
(Month) (Day) (Year)

7 AGE 24 yrs. 7 mos. 8 ds. If LESS than 1 day, .... hrs. or .... min.?

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

9 BIRTHPLACE (State or country) Potter Co

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (State or country) N.C.

12 MAIDEN NAME OF MOTHER Sarah E. Paris

13 BIRTHPLACE OF MOTHER (State or country) Jackson Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs M J Jackson

(Address) Blossington Sp

15 Filed Dec 17, 1918 Ernest Wheeler

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16, 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1918, to Dec 16, 1918,  
that I last saw him alive on Dec 16, 1918,  
and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH\* was as follows:  
Spanish Influenza

(Duration) .... yrs. .... mos. 3 ds.

Contributory Bacterial Pneumonia  
(SECONDARY) (Duration) .... yrs. .... mos. 8 ds.

(Signed) Freeman & Wheeler, M. D.  
12/17, 1918 (Address) Blossington Sp

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF 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 Apple Grove Rd DATE OF BURIAL 12/17, 1918

20 UNDERTAKER Williamson Dr ADDRESS Spruille

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.