

MARGIN RESERVED FOR BINDING
 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 **STATE OF TENNESSEE** **158**
 County Jackson STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 Civil Dist. 15th CERTIFICATE OF DEATH
 or Greenwell Registration District No. 444031 File No. _____
 or _____ Primary Registration District No. _____ Registered No. _____
 City _____ (No. _____ St.; _____ Ward)

2 FULL NAME Mary B Bryant
 [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** Widow
 (Write the word)

6 DATE OF BIRTH Oct 5 1899
 (Month) (Day) (Year)

7 AGE 74 yrs. _____ mos. _____ da. If LESS than 1 day, _____ hrs. or _____ min.?
 If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER B. W. Roberts
11 BIRTHPLACE OF FATHER (State or country) Tennessee
12 MAIDEN NAME OF MOTHER M. C. Hill
13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] John C. Bush
 [Address] _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 13 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1917 to Feb 12 1917, that I last saw her alive on Feb 12 1917 and that death occurred, on the date stated above, at 10 P.M.
 The CAUSE OF DEATH* was as follows:
Pneumonia
1000
 [Duration] _____ yrs. _____ mos. _____ da.

Contributory [SECONDARY] _____ [Duration] _____ yrs. _____ mos. _____ da.
 Signed L. M. Humes M. D.
 _____, 191____ Address Greenwell

* 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. _____ da. In the State _____ yrs. _____ mos. _____ da.
 Where was disease contracted, if not at place of death?
 Former or usual residence _____

15 Filed _____ M. Donna M. Fairbairn REGISTRAR

19 PLACE OF BURIAL OR REMOVAL at Home **DATE OF BURIAL** Feb 14 1918
20 UNDERTAKER William A. Bush **ADDRESS** Greenwell