

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** 172
 County Jackson STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 Civil Dist. 6th CERTIFICATE OF DEATH
 OR Registration District No. 442 File No. _____
 Village Gainsboro Rte 2 Primary Registration District No. _____ Registered No. 6
 OR City _____ (No. _____ St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Roy MEW

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 3 23 1915
 (Month) (Day) (Year)

7 AGE 4 yrs. 11 mos. 15 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Albert Mew

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Albert Mew
 [Address] Gainsboro Rte 2

15 Filed April 1920 A. J. Pharris
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 8 1920
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from 3-1-1920 to 3-3-1920, that I last saw him alive on 3-3-1920 and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows: 100a
Pneumonia fever
(Bronchial)

[Duration] ____ yrs. ____ mos. ____ ds.
 Contributory [SECONDARY] _____ [Duration] ____ yrs. ____ mos. ____ ds.

Signed Wm Brown M. D.
3 25 1920 Address 111th St 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 unknown **DATE OF BURIAL** unknown 1920

20 UNDERTAKER unknown **ADDRESS** _____