

1 PLACE OF DEATH

County JacksonCivil Dist. 4

or Village _____

or City _____ (No. _____, _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

174

Registration District No. 442

File No. _____

Primary Registration District No. _____

Registered No. 5

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas Edward Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED 2e
Write the word6 DATE OF BIRTH November 28, 1867
(Month) (Day) (Year)7 AGE 52 yrs. 3 mos. 19 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) Gainesboro10 NAME OF FATHER James Anderson11 BIRTHPLACE OF FATHER (State or country) Gainesboro12 MAIDEN NAME OF MOTHER Soubon Allen13 BIRTHPLACE OF MOTHER (State or country) Gainesboro

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vernia Anderson(Address) Gainesboro15 Filed Feb 10, 1920 A. J. Pharris
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 10, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: 31no medical aid in attendance
tuberculosis or succumb to
the Residence and at the fact
about
(Duration) 20 yrs. _____ mos. _____ ds.

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

(Signed) A. J. Pharris Reg, M. D.Feb 10, 1920 (Address) _____

*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 McCoin center DATE OF BURIAL Feb 11, 192020 UNDERTAKER Loan ADDRESS _____

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.