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.

STATE OF TENNESSEE

196

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Jackson
Civil Dist. First Registration District No.
or Village Gainesboro Primary Registration District No.
or City (No. St.; Ward)

File No. 14
Registered No.
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Armon Chaffin

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day), 1 (Year)

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

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

9 BIRTHPLACE (State or country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15
Filed June 7 1920 T. H. W. G. Hill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 15, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 15 1920, to April 15, 1920,
that I last saw him alive on April 15, 1920,
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Meningitis following Influenza
(Duration) yrs. mos. ds.
Contributory (SECONDARY)
(Duration) yrs. mos. ds.
(Signed) O. C. Fowler, M. D.
April 30, 1920 (Address) Gainesboro

*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 Harris Cemetery
DATE OF BURIAL April 16, 1920
20 UNDERTAKER None
ADDRESS

Form V. S. No. 4—25M. FOSTER & PARKES CO., NASHVILLE