

## 1 PLACE OF DEATH

County Jackson  
 Civil Dist. 5<sup>th</sup>  
 OR  
 Village Groville  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

STATE OF TENNESSEE 197

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

Registration District No. H440 S1  
 Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

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

2 FULL NAME Maddie Boyles Myers

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX m. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)

6 DATE OF BIRTH Feb. 20 1893  
 (Month) (Day) (Year)

7 AGE 27 yrs. 2 mos. 10 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) Groville Tenn.

10 NAME OF FATHER Nicholas B. Myers

11 BIRTHPLACE OF FATHER (State or country) Groville Tenn.

12 MAIDEN NAME OF MOTHER Mary E. Elizabeth Little

13 BIRTHPLACE OF MOTHER (State or country) Chattanooga Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] \_\_\_\_\_

[Address] \_\_\_\_\_

15 Filed \_\_\_\_\_ BY Dora M. Gailbreath REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 18 1920  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 14 1920 to Apr 18 1920, that I last saw him alive on Apr 17 1920, and that death occurred, on the date stated above, at 5:20 pm

The CAUSE OF DEATH\* was as follows:  
Mastoid abscess and perforation into brain  
probable [Duration] 20 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory [SECONDARY] \_\_\_\_\_ [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed J. W. Crawford M. D.  
7/27 1920 Address Groville

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 Smith Cemetery DATE OF BURIAL Apr 18 1920

20 UNDERTAKER Williamson Bus ADDRESS Groville

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.