

WRITE PLAIN 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**  
STATE BOARD OF HEALTH  
Bureau of Vital Statistics  
**CERTIFICATE OF DEATH**

248

1 PLACE OF DEATH  
County Jackson  
Civil Dist. 11 Registration District No. 44411 File No. \_\_\_\_\_  
or Village \_\_\_\_\_ Primary Registration District No. 11 Registered No. 7  
or City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
2 FULL NAME Chas Lawson  
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH 9 20, 1912  
(Month) (Day) (Year)

7 AGE 7 yrs., 11 mos., 6 ds. IF LESS than 1 day, ---hrs. or ---min.?

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

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Bill Lawson

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Emmy Welch

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Bill Lawson  
(Address) Yasoville R#1

15 Filed 9/6, 1920 L. L. Anderson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH 8 26, 1920  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/25, 1920, to 8/26, 1920, that I last saw him alive on 8/26, 1920 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH\* was as follows:  
Scarlet Fever

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.  
Contributory acute nephritis  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.  
(Signed) L. L. Anderson, M. D.  
8/27, 1920 (Address) Yasoville

\*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 Allen Cem. DATE OF BURIAL 8/27, 1920

20 UNDERTAKER B. M. Morgan ADDRESS Franklin