

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 283
STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County Jackson
 Civil Dist. East Registration District No. 144-1 File No. 11
 or Village Garrettsville Primary Registration District No. 144-1-a Registered No. _____
 or City _____ (No. _____, _____ St.; _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hannidauna Grady

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 21st 25, 1920
 (Month) (Day) (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) Jackson Co

PARENTS

10 NAME OF FATHER Sam Grady
 11 BIRTHPLACE OF FATHER (State or country) Jackson Co
 12 MAIDEN NAME OF MOTHER Jennie Wheeler
 13 BIRTHPLACE OF MOTHER (State or country) Gretna Co Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. H. Young
 (Address) Garrettsville

15 Filed Sept 25 1920 W. H. Little
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25, 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 _____.

The CAUSE OF DEATH* was as follows: 11/5/20

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____, M. D.
 _____, 191____ (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 Wheeler Burial Yard DATE OF BURIAL Sept 27, 1920
 20 UNDERTAKER None ADDRESS _____