

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.

**1 PLACE OF DEATH**  
 County Jackson  
 Civil Dist. #4  
 OR  
 Village  
 OR  
 City (No. St. Ward)

**STATE OF TENNESSEE**  
 STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH  
 Registration District No. 44404  
 Primary Registration District No.  
 File No.  
 Registered No. 16

298

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

**2 FULL NAME** Mary Francis Lippner

**PERSONAL AND STATISTICAL PARTICULARS**

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

**6 DATE OF BIRTH**  
Not known  
 (Month) (Day) (Year)

**7 AGE**  
68 yrs. - mos. - da. or min.?  
 If LESS than 1 day, hrs.

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

**9 BIRTHPLACE**  
 (State or country) Tenn.

**10 NAME OF FATHER** George Clinton  
**11 BIRTHPLACE OF FATHER** N.C.  
**12 MAIDEN NAME OF MOTHER** Martha Ferguson  
**13 BIRTHPLACE OF MOTHER** Not known

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**  
Dec-15-1920  
 [Month] [Day] [Year]

**17 I HEREBY CERTIFY, That I attended deceased from**  
July 8, 1920, to Dec 15, 1920,  
 that I last saw her alive on Nov. 20, 1920,  
 and that death occurred, on the date stated above, at 6 A.M.  
 The CAUSE OF DEATH\* was as follows:  
Heartd. insufficiency  
 [Duration] 3 yrs. - mos. - da.  
 Contributory Chronic Interstitial Nephritis  
 [SECONDARY] [Duration] 10 yrs. - mos. - da.  
 Signed Frank B. Clark M. D.  
Dec. 15, 1920 Address Haydenburg

\* 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.....da. In the State.....yrs.....mos.....da.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 [Informant] Will Lippner  
 [Address] Haydenburg Tenn

**15**  
 Filed Dec 27, 1920 Patt Clark

**19 PLACE OF BURIAL OR REMOVAL** W.S. Hances  
**DATE OF BURIAL** Dec 16, 1920

**20 UNDERTAKER** H.B. Webb  
**ADDRESS** Haydenburg Tenn