

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

## 1 PLACE OF DEATH

County JacksonCivil Dist. no 2OR  
Village HaydenburgOR  
City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)Registration District No. 44402Primary Registration District No. 2File No. 318Registered No. 1

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

2 FULL NAME Fountain Lee

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
(Write the word)6 DATE OF BIRTH Oct 11 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 Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Jackson Co Tenn10 NAME OF FATHER Jones Lee11 BIRTHPLACE OF FATHER (State or country) Jackson Co Tenn12 MAIDEN NAME OF MOTHER Malissie Allen13 BIRTHPLACE OF MOTHER (State or country) Jackson Co Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] \_\_\_\_\_

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

15 Filed Feb 29 1921 Aloug McBawley  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 24 1921  
(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 \_\_\_\_\_ M

The CAUSE OF DEATH\* was as follows:  
Unknown found dead in bed, on the morning of Feb 24 - 1921  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 DATE OF BURIAL Feb 25 1921Parkman Grove just20 UNDERTAKER none ADDRESS \_\_\_\_\_suppose a friend actedA very poor manMARGIN 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.