

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. 11
 or
 Village _____
 or
 City _____ (No. _____; _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

Registration District No. 4841
 Primary Registration District No. 11

File No. 339
 Registered No. 4

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

2 FULL NAME Stillborn

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 3 5, 1921
 (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) Tenn.

10 NAME OF FATHER Louie Carr

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Mollie Platt

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Louie Carr
 (Address) Gambour 73

16 Filed 5/16, 1921 L. H. Henderson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 5, 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:
S

..... (Duration) yrs. mos. ds.

Contributory (SECONDARY) _____
 (Signed) L. H. Henderson, M. D.,
3/6, 1921 (Address) Gambour 73

*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 Platt Cem. DATE OF BURIAL 3/6, 1921

20 UNDERTAKER Refo Platt ADDRESS Gambour 73