

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

## 1 PLACE OF DEATH

County JacksonCivil Dist. #1Village Near Gainesboroin the Poor house (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)Registration District No. 441Primary Registration District No. 4400File No. 6347

Registered No. \_\_\_\_\_

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

2 FULL NAME Martha Keith

## 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 May 2, 1921  
(Month) (Day) (Year)7 AGE about 6 1/2 years IF LESS than 1 day, ---- hrs. or ---- min.?  
-----yrs.-----mos.-----ds.8 OCCUPATION  
(a) Trade, profession, or particular kind of work was house wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Jackson County10 NAME OF FATHER Robert Arch Dill11 BIRTHPLACE OF FATHER (State or country) Jackson County12 MAIDEN NAME OF MOTHER Caroline Dill13 BIRTHPLACE OF MOTHER (State or country) Jackson County

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Billard Anderson(Address) Gainesboro, Route #115 Filed May 7, 1921 M. M. R. Little  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2, 1921  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to April 23, 1921, that I last saw her alive on April 23, 1921, and that death occurred, on the date stated above, at 3 P.M.The CAUSE OF DEATH\* was as follows: 16c  
Chronic Disentery and  
had some Syphilis and  
Chronic Kidney trouble.  
of long standing (Duration) ---- yrs. ---- mos. ---- ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) ---- yrs. ---- mos. ---- ds.

(Signed) Henry D. Little, M. D.May 6, 1921 (Address) Gainesboro

\*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 May 7, 1921

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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.