

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. First
Village Gainesboro
or
City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 441
Primary Registration District No. 24401

File No. 9349
Registered No. _____

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

2 FULL NAME Donald Rubin Burris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>Apr 29, 1921</u> (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) Gainesboro

PARENTS

10 NAME OF FATHER Ray Burris

11 BIRTHPLACE OF FATHER (State or country) Jackson Co

12 MAIDEN NAME OF MOTHER Pippel Spurbach

13 BIRTHPLACE OF MOTHER (State or country) Jackson Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed June 9, 1921 Meacham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1921
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1921, to May 3, 1921, that I last saw him alive on May 3, 1921, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

long tubercular disease with
1590

Contributory (SECONDARY) _____

(Signed) Leah E. Burris M. D.
_____, 191____ (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

20 UNDERTAKER

ADDRESS _____