

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.

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Jackson  
Civil Dist. 14  
or Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

Registration District No. 44414  
Primary Registration District No. 14

File No. 355

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

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

2 FULL NAME Mary Poley Carter

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH \_\_\_\_\_, 1906  
(Month) (Day) (Year)

7 AGE about 85 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) \_\_\_\_\_

PARENTS  
10 NAME OF FATHER Dont Know  
11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_  
12 MAIDEN NAME OF MOTHER Lily Pharis  
13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Thea Brown Daughter  
(Address) Hoydenburg Tenn

15 Filed Jan 9, 1921 Bungby REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 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:

Dont Know Cause of Death  
Didnt know I know  
Doctor  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 205h

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 Stallard Grayford DATE OF BURIAL May 20, 1921  
20 UNDERTAKER Russell ADDRESS \_\_\_\_\_