

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. P
 OR
 Village _____
 OR
 City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

Registration District No. 44401
 Primary Registration District No. _____

File No. 360
 Registered No. 6

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

2 FULL NAME A. S. Loukford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX boy 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)
 6 DATE OF BIRTH Sept 8 1920
 (Month) (Day) (Year)
 7 AGE _____ yrs. 7 mos. 29 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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) Jackson co Tenn

10 NAME OF FATHER Charles Loukford

11 BIRTHPLACE OF FATHER [State or country] Jackson co

12 MAIDEN NAME OF MOTHER Sou Verna Stewart

13 BIRTHPLACE OF MOTHER [State or country] Jackson co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Charles Loukford

[Address] Cookeville R 8

15 Filed June 15 1921 A. M. Ballard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 7 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:

Dysentery. Supposed to be
There was no medical
aid [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? at home
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Dodson branch DATE OF BURIAL June 6 1921

20 UNDERTAKER Friends ADDRESS _____