

# STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

### 1 PLACE OF DEATH

County Jackson  
Civil Dist. 8  
OR  
Village \_\_\_\_\_  
OR  
City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

Registration District No. HH 408  
Primary Registration District No. \_\_\_\_\_

File No. 11409

Registered No. \_\_\_\_\_  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

### 2 FULL NAME Mae Rogers

#### PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) A

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

7 AGE 20 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer).

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER Jim Warren

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Minnie Moss

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
[Informant] Sissie Loftis

[Address] Gainesboro Tenn

15 Filed Nov. 10, 1921 Mrs. T. M. Cotton REGISTRAR

#### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 9 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:

Puerperal Eclampsia 148

[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Contributory [SECONDARY] \_\_\_\_\_

[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Signed R. C. Bow \_\_\_\_\_ 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 Crowder Cem. DATE OF BURIAL Nov. 9 1921

20 UNDERTAKER None ADDRESS \_\_\_\_\_

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.