

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. 1
 or
 Village _____
 or
 City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

Registration District No. 44408
 Primary Registration District No. _____

File No. 8294
 Registered No. 8

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

2 FULL NAME Daisy B. Allen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.M. 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH April 7, 1920
 (Month) (Day) (Year)

7 AGE 1 8 20 If LESS than 1 day, hrs. or min.?
 yrs. mos. ds.

8 OCCUPATION non
 (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) Tenn

10 NAME OF FATHER Marion Allen

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Mary M. Hamilton

13 BIRTHPLACE OF MOTHER (State or country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] A. Berry Hamilton
 [Address] Cou Perille Tenn

15 Filed Sept-15-22 A. M. Ballard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 27, 1925
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____ from _____ 191____ to _____ 191____
 that I last saw h_____ alive on _____ 191____
 and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:
Cause unknown
no medical aid in attendance died sudden

[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?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Dodson Branch DATE OF BURIAL Jan 28, 1925

20 UNDERTAKER Friends only ADDRESS _____