

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. 9
 OR
 Village _____
 OR
 City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 144408
 Primary Registration District No. _____

File No. 363
 Registered No. 5

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

2 FULL NAME Francis Charlotte Loftis Allen

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Oct 4 1882
 (Month) (Day) (Year)

7 AGE 88 yrs. 8 mos. 0 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) Tenn

10 NAME OF FATHER Tom Loftis

11 BIRTHPLACE OF FATHER [State or country] Tenn

12 MAIDEN NAME OF MOTHER Betsy Hinde

13 BIRTHPLACE OF MOTHER [State or country] Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Rufus Allen
 [Address] Cookville Tenn

15 Filed July 24 1922 C. M. Ballard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4 1922
 [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:
no medical aid in attendance
 [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 14 yrs. 0 mos. 0 ds. In the all his life 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's branch DATE OF BURIAL July 5 1922
 20 UNDERTAKER Friends only ADDRESS _____