

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. No 8  
OR  
Village \_\_\_\_\_  
OR  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. H4408  
Primary Registration District No. \_\_\_\_\_

File No. 293  
Registered No. \_\_\_\_\_

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

2 FULL NAME Mrs. Annie Spivey

### PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE X yrs. 11 mos. X ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION Housewife  
(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 As Hawkins

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Sarah Hawkins

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
[Informant] Henry Hall  
[Address] Same as above

15 Filed Oct 11 1922 Wm. J. McEwen  
REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5 1922  
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Sept 17 1922 to Oct 5, 1922, that I last saw her alive on Oct 5, 1922 and that death occurred, on the date stated above, at 11 'M

The CAUSE OF DEATH\* was as follows:  
Died of death by fire, the explosion of a lamp  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Signed L. C. Spivey M. D.  
Oct 7 1922 Address Same as above

\* 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 Ray Goodford DATE OF BURIAL Oct 6 1922  
20 UNDERTAKER None ADDRESS \_\_\_\_\_