

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. 44408
 Primary Registration District No. _____

File No. 477
 Registered No. 16

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

2 FULL NAME Sarah Murlen

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH June 15 1888
 (Month) (Day) (Year)

7 AGE 84 yrs. 5 mos. 16 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) unknown

10 NAME OF FATHER Arch Turner

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER W.A. West

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Mrs. Estell Roberts
 [Address] Cookville, T.S.

15 Filed Dec 20 1928 W. M. Ballard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 1 1928
 (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: 205a

A Medical Aid
Heart failure the cause of D.
 [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 all her life

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Dodson Branch Dec 2 1928

20 UNDERTAKER ADDRESS
Friends Only