

MARGIN RESERVED FOR BINING
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. 15
or
Village _____
or
City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

424
File No. 14
Registered No. _____

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

2 FULL NAME

Duffe Strong

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH 4 1 _____ 192 _____
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER Luther Strong

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Emilia Hix

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Casada
(Address) Sainesboro

15 Filed Dec 22 1922 W. J. Casada REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 18 192 2
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 192 _____ to _____ 192 _____ that I last saw him _____ alive on _____ 192 _____ and that death occurred, on the date stated above, at _____ M
The CAUSE OF DEATH* was as follows:

Bolt Hinder 205a

Contributory [SECONDARY] _____

Signed _____ M. D.
_____ 192 _____ 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 Pharris Cemetery DATE OF BURIAL Dec 18 192 _____
20 UNDERTAKER none ADDRESS _____