STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

331

1 PLACE OF DEATH
County Jackson
Civil Dist. 9
OR
Village
OR
City (No. St.; Ward)

Registration District No. 44408
Primary Registration District No.

File No. 4
Registered No. 4
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary E Allen Jackson

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.

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH: feb (Month) 8 (Day), 1860 (Year)

7 AGE: 62 yrs., 11 mos., 22 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

PARENTS
10 NAME OF FATHER: Zack Allen
11 BIRTHPLACE OF FATHER [State or country]: Tenn
12 MAIDEN NAME OF MOTHER: Emeline Huffman
13 BIRTHPLACE OF MOTHER [State or country]: Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] Mary Nelson
[Address] Cookeville R 3

15 Filed feb 4 1923 G. M. Ballard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 30 (Day), 1923 (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: 11 h
Influenza
no Doctor
[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 all her life yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Smith Chapel
DATE OF BURIAL: feb 1st 1923
20 UNDERTAKER: Friends
ADDRESS