

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 341  
STATE BOARD OF HEALTH  
Bureau of Vital Statistics  
CERTIFICATE OF DEATH  
Registration District No. 44408 File No. 2  
Primary Registration District No. \_\_\_\_\_ Registered No. 2  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Elizabeth Phillipse

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Jan 3 1914  
(Month) (Day) (Year)

7 AGE 0 28 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
yrs. mos. ds.

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) Jackson Co

10 NAME OF FATHER Mike Phillipse

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Manervia Under

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
[Informant] Asberry Hamilton  
[Address] Cooksville B8

15 Filed Feb 4 1923 A. M. Ballard  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 2 1923  
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from 191 \_\_\_\_\_ to \_\_\_\_\_, 191 \_\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 191 \_\_\_\_\_

and that death occurred, on the date stated above, at \_\_\_\_\_ M

The CAUSE OF DEATH\* was as follows: 2051

unknown  
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. State all his 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 3 1923

20 UNDERTAKER Friend ADDRESS \_\_\_\_\_