STATE OF TENNESSEE

381

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

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.

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

1 PLACE OF DEATH

County Jackson

Civil Dist. 6 or Village or City Gainesboro (No. ____, ____ St.; ____ Ward)

Registration District No. ____ File No. ____

Primary Registration District No. 442 Registered No. 3

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

2 FULL NAME Howard Jones Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH March (Month) 31 (Day), 1923 (Year)

7 AGE ____ yrs. ____ mos. 12 ds. If LESS than 1 day, ____ hrs. or ____ min.?

8 OCCUPATION
(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) Gainesboro

PARENTS

10 NAME OF FATHER Jourdon Anderson

11 BIRTHPLACE OF FATHER (State or country) Gainesboro

12 MAIDEN NAME OF MOTHER Ava Rhoton

13 BIRTHPLACE OF MOTHER (State or country) Gainesboro

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jourdon Anderson

(Address) Gainesboro

15

Filed May 28, 1923 A. J. Rhoton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 13 (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: No Medical aid in attendance

(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 ____

19 PLACE OF BURIAL OR REMOVAL Wa[illegible]

DATE OF BURIAL April 15, 1923

20 UNDERTAKER —

ADDRESS ____

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