

# STATE OF TENNESSEE 362

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

### 1 PLACE OF DEATH

County Jackson

Civil Dist. 4

OR  
Village \_\_\_\_\_

OR  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. \_\_\_\_\_

Primary Registration District No. 442

File No. \_\_\_\_\_

Registered No. 3

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

2 FULL NAME Eura Johnson

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Mar  
(Write the word)

6 DATE OF BIRTH Oct 10 1890  
(Month) (Day) (Year)

7 AGE 35 yrs. 2 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House Keeping  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Gaines bond

10 NAME OF FATHER James Reed

11 BIRTHPLACE OF FATHER (State or country) Gaines bond

12 MAIDEN NAME OF MOTHER Hany Ann

13 BIRTHPLACE OF MOTHER (State or country) Gaines bond

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] J. Lynn  
[Address] Gaines bond

15 Filed Jan 16 1924 A. J. Pharris REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 21 1924  
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 192\_\_\_\_ to \_\_\_\_\_ 192\_\_\_\_

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 192\_\_\_\_ and that death occurred, on the date stated above, at \_\_\_\_\_ M

The CAUSE OF DEATH\* was as follows:  
No Physician in attendance had bad case of typhoid & missed carriage tire in that time after miscarriage [Duration] yrs. mos. ds.

Contributory [SECONDARY] \_\_\_\_\_ 143a [Duration] yrs. mos. ds.

Signed A. J. Pharris Reg. \_\_\_\_\_ 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 Lynn cemetery DATE OF BURIAL Jan 22 1924

20 UNDERTAKER Asa Lynn ADDRESS Gaines bond

DO NOT TEAR OUT  
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.