

MARGIN RESERVED FOR BINDING 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. 14
 OR
 Village _____
 OR
 City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

374 3

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

Registration District No. 14414
 Primary Registration District No. 14

File No. _____

Registered No. _____

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

2 FULL NAME Tom, Hughes

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 7 5 1865
(Month) (Day) (Year)

7 AGE 58 yrs. 3 mos. 5 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION Farming 000
(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) Jackson

10 NAME OF FATHER Sam Hughes

11 BIRTHPLACE OF FATHER (State or country) Ky.

12 MAIDEN NAME OF MOTHER Dont No.

13 BIRTHPLACE OF MOTHER (State or country) Dont No.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Bill Hughes
 [Address] Deputed Jones

15 Filed 3-7 1924 Benny Ray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 10 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: 31
Atk No. Dr. But Evid 31
Pronounced this cause of death
tuberculosis. Two boys of this
man died. With this cause

Contributory Last year
[SECONDARY] (Duration) yrs. mos. ds.

Signed _____ M. D.
 _____ 192____ Address _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE CAUSED 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, DATE OF BURIAL
Woodland Cemetery 2-11 1924

20 UNDERTAKER ADDRESS
G. F. M. Purcell Deputed