

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

386

1 PLACE OF DEATH

County Jackson
Civil Dist. 9
OR
Village _____
OR
City _____ (No. _____ St.; _____ Ward)

Registration District No. 44409
Primary Registration District No. _____

File No. 8
Registered No. 3

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

2 FULL NAME

Willie Brown Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Boy</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>March 27</u> : <u>1921</u> <small>(Month) (Day) (Year)</small>		
7 AGE <u>2</u> yrs. <u>11</u> mos. <u>12</u> ds.		8 If LESS than 1 day, ___ hrs. or ___ min.?
8 OCCUPATION <small>(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).</small>		
9 BIRTHPLACE (State or country) <u>Jackson County</u>		
PARENTS	10 NAME OF FATHER <u>D. W. Hamilton</u>	
	11 BIRTHPLACE OF FATHER [State or country] <u>Jackson Co.</u>	
	12 MAIDEN NAME OF MOTHER <u>Rebecky Rector</u>	
	13 BIRTHPLACE OF MOTHER [State or country] <u>Jackson Co.</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE [Informant] <u>D. W. Hamilton</u> [Address] <u>Cookeville R. 5</u>		
15 Filed <u>April 10</u> by <u>A. M. Ballard</u>		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 27 1921
(Month) (Day) (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 _____
The CAUSE OF DEATH* was as follows:
no medical aid
measles [Duration] _____ yrs. _____ mos. _____ ds.
Contributory [SECONDARY] _____ [Duration] _____ yrs. _____ mos. _____ ds.
Signed _____
Address _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, 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
New Hope in Jackson

DATE OF BURIAL
Feb 28

20 UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY. 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.