

REPRODUCED FROM THE ORIGINAL RECORD

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. 5  
OR  
Village \_\_\_\_\_  
OR  
City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics  
CERTIFICATE OF DEATH

474

Registration District No. 44405

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

Primary Registration District No. 5

Registered No. \_\_\_\_\_

2 FULL NAME Ova Ann Callier

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 11 20 1889  
(Month) (Day) (Year)

7 AGE 35 yrs. 0 mos. 8 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE Tennessee  
(State or country)

10 NAME OF FATHER P. Y. Carter

11 BIRTHPLACE OF FATHER Tennessee

12 MAIDEN NAME OF MOTHER Jennie Sample

13 BIRTHPLACE OF MOTHER \_\_\_\_\_  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
[Informant] Mrs. Jennie Carter

[Address] Spencerville Rd.

15 Filed Dec. 1, 1924 H. S. Holliman

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 12 1924  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1924 to Nov. 12, 1924 that I last saw her alive on Nov. 12, 1924 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows: Pulmonary T. B. 31  
[Duration] 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Signed L. R. Anderson M. D.  
11/15 1924 Address Spencerville

\* State the DISEASE CAUSING DEATH, or, in deaths from TOILET 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 Carter Cess. DATE OF BURIAL 11/13 1924

20 UNDERTAKER H. S. Holliman ADDRESS Spencerville