

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.

1 PLACE OF DEATH

STATE OF TENNESSEE 482

County Jackson
 Civil Dist. 9
 OR
 Village _____
 OR
 City _____

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 44409 File No. 11
 Primary Registration District No. _____ Registered No. _____
 (No. _____, _____ St.; _____ Ward)

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 6 DATE OF BIRTH March 2, 1924
 (Month) (Day) (Year)
 7 AGE 9 yrs. mos. da. If LESS than 1 day, ____ hrs. or ____ min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. none
 (b) General nature of industry, business, or establishment in which employed (or employer).

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER George Phillippe

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Martha Swan

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Dr McCom

[Address] Lombard

15 Filed Dec 1924 G. M. Ballard

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 2, 1924
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1924 to Dec 1, 1924
 that I last saw h. alive on Dec 1, 1924
 and that death occurred, on the date stated above, at _____
 The CAUSE OF DEATH* was as follows: 101.6

Pneumonia

[Duration] yrs. mos. da.

Contributory [secondary] _____ [Duration] yrs. mos. da.

Signed _____ M. D.
 _____ 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. da. State yrs. mos. da.
 Where was disease contracted, if not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Green Cem DATE OF BURIAL Dec 3

20 UNDERTAKER none ADDRESS _____