

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. No 8  
 OR  
 Village \_\_\_\_\_  
 OR  
 City Gainesboro (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

1005

Registration District No. 44408

File No. 1

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

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

2 FULL NAME George W. Buehler

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE American 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED?  (Write the word)

6 DATE OF BIRTH \_\_\_\_\_ 1 \_\_\_\_\_ (Month) (Day) (Year)

7 AGE 67 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

9 BIRTHPLACE (State or country) W. Jackson Co., Tenn

10 NAME OF FATHER \_\_\_\_\_

11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER \_\_\_\_\_

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] \_\_\_\_\_

[Address] \_\_\_\_\_

15 \_\_\_\_\_

Filed \_\_\_\_\_ 1927 Mar 4 no case REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH \_\_\_\_\_ 1927  
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1927 to Jan 9 1927, that I last saw him alive on Jan 9 4 a.m. 1927 and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH\* was as follows:  
Concussion of Brain caused from falling off running board of Ford Cab on which he was riding 19 Hours  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory None  
 [SECONDARY] \_\_\_\_\_ [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed C. E. Reeves M. D.  
1/12 1927 Address Gainesboro Tenn

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. State whether or not an operation was performed.

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 \_\_\_\_\_

20 UNDERTAKER Hyman Constable ADDRESS \_\_\_\_\_

no