# STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

7953

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. 5th

OR Village Gravelly Spr

OR City ..... (No. ....., ..... St.; ..... Ward)

Registration District No. .....

Primary Registration District No. .....

File No. .....

Registered No. .....

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

2 FULL NAME Ed B. Myers

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | single |

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7 AGE ..... yrs. 20 mos. ..... ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(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)

PARENTS

10 NAME OF FATHER Edgar Myers

11 BIRTHPLACE OF FATHER [State or country]

12 MAIDEN NAME OF MOTHER Hattie Bridwell

13 BIRTHPLACE OF MOTHER [State or country]

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] .....

[Address] .....

15

Filed Apr 20, 1927 W. S. Holleman REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 16, 1927 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1927, to Apr 16, 1927, that I last saw h alive on Apr 15, 1927, and that death occurred, on the date stated above, at 7:50 A M

The CAUSE OF DEATH* was as follows:

Convulsions Organ not known never saw this case until 3 hours before death

[Duration] ..... yrs. ..... mos. 1 day

Contributory [SECONDARY] 80

[Duration] ..... yrs. ..... mos. ..... ds.

Signed L. M Freeman M. D.

..... 192 .... Address .....

* 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 ..... 192..

20 UNDERTAKER Watts & Co ADDRESS Brownsville