

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. 6th
 OR
 Village _____
 OR
 City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 44406

File No. 51

Primary Registration District No. _____

Registered No. _____

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

2 FULL NAME Eliza May Stafford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single
 6 DATE OF BIRTH April 28 1927
 7 AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
 yrs. mos. ds.

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) Jackson Co

10 NAME OF FATHER Escoe Stafford

11 BIRTHPLACE OF FATHER (State or country) Jackson Co

12 MAIDEN NAME OF MOTHER annie Stafford

13 BIRTHPLACE OF MOTHER (State or country) Jackson Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Eliza Stafford
 [Address] Gainesboro Tenn

15
 Filed May 2 1927 Mrs T. H. Weston
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 28 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 192 to _____ 192
 that I last saw h. alive on _____ 192
 and that death occurred, on the date stated above, at _____ M
 The CAUSE OF DEATH* was as follows: 7056

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

Contributory [SECONDARY] _____
 [Duration] _____ yrs. _____ mos. _____ ds.
 Signed _____ 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 Scott Cemetery DATE OF BURIAL April 28 1927

20 UNDERTAKER _____ ADDRESS _____