

MARGIN RESERVED FOR BINDING.
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. 2
or Village Hainsboro R.
or City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 44402
Primary Registration District No. 2

File No. 16
Registered No. 16

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

2 FULL NAME Mrs. Albertine Huffines

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH April 25, 1880
(Month) (Day) (Year)

7 AGE 47 yrs. 1 mos. 28 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

9 BIRTHPLACE (State or country) Tenn.

10 NAME OF FATHER Joel Harkins

11 BIRTHPLACE OF FATHER (State or country) Jackson Co. Tenn.

12 MAIDEN NAME OF MOTHER Cassandra Ray

13 BIRTHPLACE OF MOTHER (State or country) Jackson Co. Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____ (Address) _____

15 Filed June 26, 1927 Along M. Lawley

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 23, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1927, to June 23, 1927, that I last saw her alive on June 23, 1927, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Influenza, Complicated by Cholerae typhoid and rupture of the gall bladder
(Duration) ____ yrs. ____ mos. 7 ds.

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) R. C. Gaud M. D.
6/23, 1927 (Address) Spencer

*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. ____ 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

Camp Ground Cemetery 24 June 1927

20 UNDERTAKER H. H. M. Russell ADDRESS Spencer