

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 6  
 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  
 Primary Registration District No. \_\_\_\_\_

12354  
 File No. 6

Registered No. \_\_\_\_\_  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Andrew Adwell Carliles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
 (Write the word)

6 DATE OF BIRTH January 26 1927  
 (Month) (Day) (Year)

7 AGE 4 yrs. 3 mos. 4 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) Jackson Co

10 NAME OF FATHER Lige Carliles

11 BIRTHPLACE OF FATHER [State or country] Jackson Co

12 MAIDEN NAME OF MOTHER Hattie Lynn

13 BIRTHPLACE OF MOTHER [State or country] Jackson Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Joe Lynn  
 [Address] Hainesboro

15 Filed July 8, 1927 Mrs T H Noctor  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 30 1927  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1927 to June 30, 1927 that I last saw him live on June 30, 1927 and that death occurred, on the date stated above, at 10 P M  
 The CAUSE OF DEATH\* was as follows:

Dysentery + Bronchitis  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory [SECONDARY] \_\_\_\_\_  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed R C Saw M. D.  
July 8, 1927 Address Hainesboro

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 Lynn Cemetery DATE OF BURIAL July 11, 1927  
 20 UNDERTAKER John Copland ADDRESS Hainesboro