

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 11
 OR
 Village _____
 OR
 City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

12957

CERTIFICATE OF DEATH 7

Registration District No. 444 11
 Primary Registration District No. 11

File No. _____
 Registered No. 3

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

2 FULL NAME Jessie James

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
 (Write the word)

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

7 AGE 8 yrs. 11 mos. 25 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) Tenn.

10 NAME OF FATHER Fred James

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Henson

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Fred James
 [Address] Greenville R. 1

15 _____

Filed 5/10, 1927, L. P. Anderson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 / 3 / 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from 3/30, 1927, to Apr 2, 1927, that I last saw her alive on Apr 2, 1927, and that death occurred, on the date stated above, at 2 PM

The CAUSE OF DEATH* was as follows:
Chorea acuta. 81
 [Duration] _____ yrs. _____ mos. 20 ds.

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

Signed L. P. Anderson M. D.
4/3 1927 Address Greenville R. 1

* 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 Anderson Cem. DATE OF BURIAL 4/3, 1927

20 UNDERTAKER Cover & Galbreath ADDRESS Greenville