STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

15452

1 PLACE OF DEATH

County Jackson
Civil Dist. 4th
OR
Village Gainesboro
OR
City ..... (No. ..... St.; ..... Ward)

Registration District No. 4441
Primary Registration District No. 444401

File No. 12
Registered No. .....

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

2 FULL NAME James Rhatton

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: mal
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Infant

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7 AGE: 2 yrs. 5 mos. 2 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

PARENTS

10 NAME OF FATHER Frank Rhatton
11 BIRTHPLACE OF FATHER [State or country] Jackson Co
12 MAIDEN NAME OF MOTHER Sara Johnson
13 BIRTHPLACE OF MOTHER [State or country] Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] Frank Rhatton
[Address] Gainesboro

15
Filed aug 9 1921 Mrs M Hartle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 28 1921
[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: 16c

Dysentery

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

Contributory [SECONDARY] .....

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

Signed C. A. Davis 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 Pharrs cemetery
DATE OF BURIAL July 29 192..

20 UNDERTAKER .....
ADDRESS .....