

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<sup>th</sup>  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

CERTIFICATE OF DEATH 15457

Registration District No. 444 11

File No. \_\_\_\_\_

Primary Registration District No. A1

Registered No. 6

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

2 FULL NAME Johnnie Harris

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 8 10 1927  
 (Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
 yrs. 11 mos. 10 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) Tenn.

10 NAME OF FATHER Russ Harris

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Fannie Jones

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Russ Harris  
 [Address] Gainesboro, Tenn.

15 File 8/10 1927 L. R. Anderson  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 30 1927  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 30<sup>th</sup> 1927 to July 29<sup>th</sup> 1927, that I last saw him alive on July 29<sup>th</sup> 1927 and that death occurred, on the date stated above, at 7:28 M. The CAUSE OF DEATH\* was as follows: 113

Acute Colitis.

[Duration] yrs. 26 ds.

Contributory Tuberculosis  
 [SECONDARY]

[Duration] yrs. 5 ds.

Signed L. R. Anderson M. D.  
7/31 1927 Address Gainesboro, Tenn.

\* 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 New Salem Cem. DATE OF BURIAL 7/31 1927

20 UNDERTAKER Wass Jones Gainesboro ADDRESS Gainesboro, Tenn.

K.P.