

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. one  
 OR  
 Village Gainesboro  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

17897

Registration District No. 441  
 Primary Registration District No. 44401

File No. 15  
 Registered No. \_\_\_\_\_

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

2 FULL NAME Mrs Edith Heady

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH March 16 1901  
(Month) (Day) (Year)

7 AGE 26 5 5 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
Yrs. mos. ds.

8 OCCUPATION Housewife  
 (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 Tenn

10 NAME OF FATHER Frank Anderson

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Mamie Dudley

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Mrs Mamie Anderson  
 [Address] Gainesboro

15 Filed Sept 8 1927 Mrs M H Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 20 1927  
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1927 to Aug 20 1927 that I last saw her alive on Aug 20 1927 and that death occurred, on the date stated above, at 6 PM

The CAUSE OF DEATH\* was as follows:  
acute Bacillary dysentery complicated by perforation and Peritonitis  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory [SECONDARY] \_\_\_\_\_  
 Signed R. C. Gosh M. D.  
Sept 8 1927 Address Gainesboro

\* 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. State \_\_\_\_\_ 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 Pharis Cemetery DATE OF BURIAL Aug 21 1927  
 20 UNDERTAKER Frank Anderson ADDRESS \_\_\_\_\_