# STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

22390

CERTIFICATE OF DEATH

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. 12

OR Village Mayfield

OR City ..... (No. ..... St.; ..... Ward)

Registration District No. 44412

Primary Registration District No. 12

File No. 12

Registered No. 12

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

2 FULL NAME Anderson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Infant

6 DATE OF BIRTH: Oct 24 (Month) (Day) ,1927 (Year)

7 AGE: ..... yrs. age 5 mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Jackson Co Tenn

PARENTS

10 NAME OF FATHER: R B Anderson

11 BIRTHPLACE OF FATHER [State or country]: Jackson Co Tenn

12 MAIDEN NAME OF MOTHER: Rosey Lee Harris

13 BIRTHPLACE OF MOTHER [State or country]: Jackson Co Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] R B Anderson

[Address] Mayfield Tenn

15 Filed Nov 1 ,192 7 John B. Billingsley

Gainesboro R 6

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 29 [Month] [Day] ,1927 [Year]

17 I HEREBY CERTIFY, That I attended deceased from ..... ,192 ..... to ..... ,192 ..... that I last saw him alive on Oct 25 ,1927 and that death occurred, on the date stated above, at 6 P M

The CAUSE OF DEATH* was as follows:

(a) Infantile Paralysis 73

from Birth

[Duration] ..... yrs. ..... mos. 5 ds.

Contributory [SECONDARY] .....

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

Signed L B Anderson M. D.

Nov 1 ,1927 Address Gainesboro R 6

* 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: Harris cemetery

DATE OF BURIAL: Oct 30 ,1927

20 UNDERTAKER: Louis Harris

ADDRESS: Gainesboro R 1