

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.

Hugh Pharris

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH **24529**

1 PLACE OF DEATH

County *Jackson*

Civil Dist. *5th*

Village *Granville*

City (No. , St.; Ward)

Registration District No. _____

Primary Registration District No. _____

File No. _____

Registered No. _____

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

2 FULL NAME *Char Jackson Pharris*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____

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

7 AGE *2* yrs. *29* da. 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*

10 NAME OF FATHER *Hugh Pharris*

11 BIRTHPLACE OF FATHER (State or country) *Jackson Co*

12 MAIDEN NAME OF MOTHER *Conrad Loftis*

13 BIRTHPLACE OF MOTHER (State or country) *Jackson Co*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] *T M Watts*

[Address] *Granville*

15 Filed *Dec 13 7* *H. S. Holloman*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 14 1927* [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from *Oct 13 1927* to *Oct 14 1927*, that I last saw *him* alive on *Oct 14 1927*

and that death occurred, on the date stated above, at *6 P M*

The CAUSE OF DEATH* was as follows: *Diphtheria Anterior*

[Duration] ____ yrs. ____ mos. ____ da.

Contributory [SECONDARY] _____

[Duration] ____ yrs. ____ mos. ____ da.

Signed *L M Freeman* M. D. Address *Granville*

* 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. ____ da. State ____ yrs. ____ mos. ____ da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Pharris* DATE OF BURIAL *Oct 15 1927*

20 UNDERTAKER *T M Watts* ADDRESS *Granville*