

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. 5th

OR Village _____

OR City Waverly (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

24536

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

2 FULL NAME Dora Duke

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Nov 23 1906
(Month) (Day) (Year)

7 AGE 19 yrs. 6 mos. 1 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Jackson

10 NAME OF FATHER Tom Hughes

11 BIRTHPLACE OF FATHER (State or country) Jackson

12 MAIDEN NAME OF MOTHER Cora Ramsey

13 BIRTHPLACE OF MOTHER (State or country) Jackson

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] Frank Duke
[Address] Waverly

15 Filed Dec 13 1927 H. S. Hollaway REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr. 23, 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 192____, to _____, 192____, that I last saw him _____ alive on _____, 192____, and that death occurred, on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows: 31

Pulmonary Hemorrhage
no vector
T.B. of Lung (Duration) _____ yrs. _____ mos. _____ ds.

Contributory [SECONDARY] _____ [Duration] _____ yrs. _____ mos. _____ ds.
Signed _____ 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 Surey Cem DATE OF BURIAL Apr 24 1927
20 UNDERTAKER Tom Watts ADDRESS Waverly