

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 _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH **24538**
 File No. _____
 Registered No. _____

2 FULL NAME Jim Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 2 (Month) 18 (Day) 1955 (Year)

7 AGE 72 yrs. 0 mos. 8 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) Tenn.

10 NAME OF FATHER William Davis

11 BIRTHPLACE OF FATHER [State or country] Tenn.

12 MAIDEN NAME OF MOTHER Eliza Burgess

13 BIRTHPLACE OF MOTHER [State or country] Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Oero Burgess
 [Address] Summerville Rd.

15 Filed 22013 1957 H. S. Hollman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 (Month) 26 (Day) 1957 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2/24, 1927, to 2/26, 1927, that I last saw him live on 2/26, 1927, and that death occurred, on the date stated above, at 11 M. The CAUSE OF DEATH* was as follows: 116

Influenza
 [Duration] _____ yrs. _____ mos. 18 ds.

Contributory Acute nephritis [SECONDARY] urinary [Duration] _____ yrs. _____ mos. 3 ds.

Signed L. R. Anderson, M. D. 2/28, 1927. Address Summerville

* 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 Winton Park DATE OF BURIAL Mich 2, 1957
 20 UNDERTAKER Timothy Co ADDRESS Summerville