

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			STATE OF TENNESSEE		
County <u>Jackson</u>			STATE BOARD OF HEALTH Bureau of Vital Statistics		
Civil Dist. <u># 7</u>			Registration District No. <u>104407</u>		Certificate of Death <u>27053</u>
OR Village			Primary Registration District No.		File No. <u>6</u>
OR City (No. , St.; Ward)			Registered No.		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Sam Brown</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	16 DATE OF DEATH <u>7</u> <u>18</u> <u>1927</u> [Month] [Day] [Year]		
6 DATE OF BIRTH _____. _____. _____. (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>June 22</u> <u>1927</u> to <u>July 9</u> <u>1927</u> that I last saw him alive on <u>July 9</u> <u>1927</u> and that death occurred, on the date stated above, at _____ M		
7 AGE <u>59</u> yrs. <u>4</u> mos. <u>2</u> ds.	If LESS than 1 day, ____ hrs. or ____ min.?		The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> <u>31</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).			[Duration] ____ yrs. ____ mos. ____ ds.		
9 BIRTHPLACE (State or country)			Contributory [SECONDARY] [Duration] ____ yrs. ____ mos. ____ ds.		
10 NAME OF FATHER			Signed <u>L M Fuman</u> M. D.		
11 BIRTHPLACE OF FATHER [State or country]			Address <u>Granville Tenn</u>		
12 MAIDEN NAME OF MOTHER			* 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.		
13 BIRTHPLACE OF MOTHER [State or country]			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 _____		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE [Informant] _____ [Address] _____			19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL <u>Brown</u> <u>July 7/27</u> <u>1927</u> ADDRESS _____		
15 Filed <u>Jan 10</u> <u>1927</u> <u>Wade</u> <u>Whelch</u> REGISTRAR			20 UNDERTAKER <u>Combs</u>		