

MARGIN RESERVED FOR BINDING

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 Gadsden

Civil Dist. 15

Village _____

City _____

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1855

Registration District No. 44415

File No. 2

Primary Registration District No. _____

Registered No. _____

2 FULL NAME Vickie Gilstrap

St.: _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 8 23 1948
(Month) (Day) (Year)

7 AGE 55 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION Home wife
(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) Tenn

10 NAME OF FATHER Rose Osgathard

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Rachel Plumbly

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] _____

[Address] _____

15 _____

Filed _____ 191 _____ Wm. Cass

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 19 1929
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 191 _____ to _____ 191 _____, that I last saw h_____ alive on _____, 191 _____ and that death occurred, on the date stated above, at _____ M The CAUSE OF DEATH* was as follows:

Influenza & Pneumonia

[Duration] _____ yrs. _____ mos. _____ ds.
Contributory [SECONDARY] _____

[Duration] _____ yrs. _____ mos. _____ ds.
Signed C. E. Reeves M. D.
_____, 191 _____ Address Isimede

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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 DATE OF BURIAL

Home Cemetery Jan 20 1929

20 UNDERTAKER ADDRESS