

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. 11<sup>th</sup>  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

8092

Registration District No. 44411  
 Primary Registration District No. 11<sup>th</sup>

File No. \_\_\_\_\_

Registered No. 3

2 FULL NAME Joe Brown Giffon

[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 Single  
 (Write the word)

6 DATE OF BIRTH 7-24 1927  
 (Month) (Day) (Year)

7 AGE 1 yrs. 6 mos. 20 ds. 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) Gen.

10 NAME OF FATHER Walter Giffon

11 BIRTHPLACE OF FATHER (State or country) Gen.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (State or country) Gen.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Walter Giffon  
 [Address] Trumbull R3

15 Filed 4/20 1929 L R Archer  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7-14 1929  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-13 1929 to 2-13 1929, that I last saw him alive on 2-13 1929 and that death occurred, on the date stated above, at 4 AM  
 The CAUSE OF DEATH\* was as follows:

Chorea. Intussusception

History of (Duration) yrs. mos. 10 ds.

Contributory [SECONDARY] See Peritonitis

(Duration) yrs. mos. 2 ds.

Signed L. R. Anderson M. D.  
7/15 1929 Address Trumbull

\* 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 Ferguson Cem. DATE OF BURIAL 2/15 1929

20 UNDERTAKER Walter Medford Giffon ADDRESS \_\_\_\_\_