

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

17720

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County JacksonCivil Dist. No. 1OR
VillageOR
City Gainesboro Tenn.Registration District No. 441Primary Registration District No. 24401

St. _____ Ward _____

File No. 15

Registered No. _____

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

2 FULL NAME Harry Preston Reptis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE American 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X6 DATE OF BIRTH 10 17 1856
(Month) (Day) (Year)7 AGE 73 yrs. 5 mos. 22 ds. If LESS than 1 day, _____ hrs. or _____ min.?8 OCCUPATION
(a) Trade, profession, or particular kind of work. Practicing Physician
(b) General nature of industry, business, or establishment in which employed (or employer) 8589 BIRTHPLACE (State or country) 9th D. Jackson Co. Tenn10 NAME OF FATHER David Reptis11 BIRTHPLACE OF FATHER (State or country) 9th D. Jackson Co. Tenn12 MAIDEN NAME OF MOTHER Samantha Harley13 BIRTHPLACE OF MOTHER (State or country) 9th D. Jackson Co. Ten

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] _____

[Address] _____

15

Filed aug 29 1929 Mr. M. H. [unclear]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 9 1929
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Jan 1929 to Jan 9 1929, that I last saw him alive on Jan 9 1929 and that death occurred, on the date stated above, at 5:30 P.M.The CAUSE OF DEATH* was as follows:
Pneumonia
Cardiovascular Renal Disease[Duration] 15 yrs. 12 mos. _____ ds.

Contributory [SECONDARY] _____

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

Signed C. E. Rees M. D."_____" 1929. Address Gainesboro Tenn

* 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 Harvard cemetery DATE OF BURIAL 10 192920 UNDERTAKER Frank [unclear] ADDRESS _____

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.