

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		
Civil Dist. <u>No. 6</u>			Bureau of Vital Statistics		
OR			17723		
Village			CERTIFICATE OF DEATH		
OR			Registration District No. <u>44406</u>		
City			Primary Registration District No.		
(No. _____) _____			File No. <u>7</u>		
2 FULL NAME <u>James Lee Anderson</u>			Registered No. _____		
St. _____			Ward _____		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	16 DATE OF DEATH <u>May 23</u> , 19 <u>29</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>May 19</u> , 1 <u>863</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 18</u> , 19 <u>28</u> , to <u>Nov 18</u> , 19 <u>28</u> , that I last saw him alive on <u>May 18</u> , 19 <u>28</u> , and that death occurred, on the date stated above, at <u>4 P. M.</u>		
7 AGE <u>66</u> yrs. <u>0</u> mos. <u>4</u> ds.			The CAUSE OF DEATH* was as follows: <u>Intermittent Tuberculosis</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer 000</u> (b) General nature of industry, business, or establishment in which employed (or employer)			[Duration] <u>10</u> yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) <u>Jackson Co</u>			Contributory [SECONDARY] _____ [Duration] _____ mos. _____ ds.		
10 NAME OF FATHER <u>Ace Anderson</u>			Signed <u>R. B. Taylor</u> M. D.		
11 BIRTHPLACE OF FATHER [State or country] <u>Jackson Co</u>			Address <u>Hamborsville</u>		
12 MAIDEN NAME OF MOTHER <u>Martha Hawkins</u>			* 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] <u>Jackson Co</u>			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] <u>Francis Anderson</u> [Address] <u>Hamborsville, Tenn.</u>			19 PLACE OF BURIAL OR REMOVAL <u>Lynn's Cemetery</u> DATE OF BURIAL <u>May 24, 1929</u>		
15 Filed <u>Aug 8, 1929</u> <u>W. H. Norton</u> REGISTRAR			20 UNDERTAKER <u>Doc Lynn</u> ADDRESS <u>Hamborsville</u>		