

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. 6th
 OR
 Village _____
 OR
 City _____ (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

20156

Registration District No. H4400
 Primary Registration District No. _____

File No. 11
 Registered No. _____

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

2 FULL NAME Rachel Wiley

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH March 23 1897
 (Month) (Day) (Year)

7 AGE 81 yrs. 4 mos. 27 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work House keeping
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tenn.

10 NAME OF FATHER Bobbie Warren

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Unicie Durbin

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Aida Wiley
 [Address] Gainesboro

15 Filed Sept 8 1929 Mrs T H Norton
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 20 1929
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929 to Aug 20 1929, that I last saw her alive on Aug 20 1929 and that death occurred, on the date stated above, at 12 A M

THE CAUSE OF DEATH* was as follows:
Chronic Myocarditis
90

[Duration] 6 yrs. _____ mos. _____ ds.

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

Signed R. C. Baird M. D.
830 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. 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 Wynne Cemetery DATE OF BURIAL Aug 21 1929

20 UNDERTAKER John Kaplan ADDRESS Gainesboro