

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. 13  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

20163

Registration District No. 44413

Primary Registration District No. 13

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

Registered No. \_\_\_\_\_

2 FULL NAME Velsie B. Sloan St.; \_\_\_\_\_ Ward) \_\_\_\_\_

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)  
 6 DATE OF BIRTH Jan. 5 1910  
 (Month) (Day) (Year)  
 7 AGE 19 yrs. 4 mos. 25 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) Tenn.

PARENTS  
 10 NAME OF FATHER Wiley Stanton Sloan  
 11 BIRTHPLACE OF FATHER (State or country) Tenn.  
 12 MAIDEN NAME OF MOTHER Mattie Elvira Wilson  
 13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Wiley Sloan  
 [Address] Hendersonburg

15 Filed Aug 2 1929 J. D. Lence  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 30 1929  
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ M

The CAUSE OF DEATH\* was as follows:  
P. B. of Bone 366  
Had no M. A. since  
1926 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory [SECONDARY] \_\_\_\_\_ [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Signed \_\_\_\_\_ M. D.  
 \_\_\_\_\_ 19\_\_\_\_ Address \_\_\_\_\_

\* 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 9 yrs. 4 mos. 25 ds. In the State 19 yrs. 4 mos. 25 ds.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Hendersonburg DATE OF BURIAL May 1 1929  
 20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_