STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

22378

CERTIFICATE OF DEATH

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. 11th

OR

Village

OR

City (No. , St.; Ward)

Registration District No. 4-9-4-11

Primary Registration District No. 11th

File No.

Registered No. 8.

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

2 FULL NAME Eva Ogeal Rogland

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: 8 (Month) – 5 (Day) – 1928 (Year)

7 AGE: 1 yrs. 0 mos. 27 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: Baugh Rogland

11 BIRTHPLACE OF FATHER [State or country]: Tenn.

12 MAIDEN NAME OF MOTHER: Ruby Autrey

13 BIRTHPLACE OF MOTHER [State or country]: Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Fannie Rogland

[Address] Gainesboro R 3

15

Filed 10-7-1929 L. R. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 9 [Month] – 2 [Day] – 1929 [Year]

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1929, to Sept 2nd 1929, that I last saw her alive on Sept 2-3, 1929 and that death occurred, on the date stated above, at 10 A M

The CAUSE OF DEATH* was as follows: 113

Chol. Infantum

[Duration] ..... yrs. ..... mos. 2 ds.

Contributory [SECONDARY] .....

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

Signed L. R. Anderson M.D.

9/3rd 1929 Address Gainesboro

* 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: Hale Cem.

DATE OF BURIAL: 9/3rd 1929

20 UNDERTAKER: T. M. Rogland

ADDRESS: Gainesboro R 3