Form V. S. 4—40M. Jan. 25, 1927.

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.

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

See #2233

24744

1 PLACE OF DEATH
County Jackson
Civil Dist. 5
OR
Village
OR
City (No. , St.; Ward)

Registration District No.
Primary Registration District No.
File No.
Registered No.
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Bill Myers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Color
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): married

6 DATE OF BIRTH: ? Aug (Month) 20 (Day) 1893 (Year)

7 AGE: 38 yrs. 8 mos. 6 ds.
If LESS than 1 day hrs. (or min.?

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

9 BIRTHPLACE (State or country): Jackson Co

PARENTS
10 NAME OF FATHER: Earl Myers
11 BIRTHPLACE OF FATHER [State or country]: Jackson
12 MAIDEN NAME OF MOTHER: Jennie Sadler
13 BIRTHPLACE OF MOTHER [State or country]: Jackson Co.

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

15
Filed 192
H. S. Kellerman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 20 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 22 192 9, to Aug 20, 1929, that I last saw him alive on Aug 12, 1929 and that death occurred, on the date stated above, at 5 P M

The CAUSE OF DEATH* was as follows:

Typhoid fever + I. B.

[Duration] yrs. mos. ds.

Contributory [SECONDARY]

[Duration] yrs. mos. ds.

Signed W. B. Paige M. D.

192 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 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
DATE OF BURIAL: Aug 21, 1929

20 UNDERTAKER: J. M. Walls + Co.
ADDRESS