

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 \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

24747

CERTIFICATE OF DEATH

Registration District No. 44413  
 Primary Registration District No. 13

File No. 137  
 Registered No. 137

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

2 FULL NAME

Rachel McDonald Caruthers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept 8 1869  
 (Month) (Day) (Year)

7 AGE 60 yrs. 1 mos. 12 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Fanner - 000  
 (b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Frankl. Caruthers

11 BIRTHPLACE OF FATHER [State or country] Tenn

12 MAIDEN NAME OF MOTHER Suzie Maryland

13 BIRTHPLACE OF MOTHER [State or country] Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Mr. Luther Caruthers  
Whitleyville  
 [Address] Whitleyville

15 Filed Oct 21 1929 J. D. Deane  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 20 - 1929  
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Aug-15-1929 to Oct-20, 1929, that I last saw him alive on Oct 20, 1929 and that death occurred, on the date stated above, at 9 P. M. The CAUSE OF DEATH\* was as follows:

1 a  
Pulmonary abscess  
following Typhoid Fever  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory [SECONDARY] \_\_\_\_\_ [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed J. D. Deane M. D.  
Oct 21 1929 Address Whitleyville

\* 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 60 yrs. 1 mos. 12 ds. In the State 60 yrs. 1 mos. 12 ds.  
 Where was disease contracted, if not at place of death?  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL Oct 21 1929

20 UNDERTAKER None ADDRESS \_\_\_\_\_