STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

24748

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. No. 8
OR
Village
OR
City

Registration District No. 44402 File No. 13
Primary Registration District No. Registered No.
(No. , St.; Ward)
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edna Richardson

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
(Month) (Day) 1 (Year)

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

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

9 BIRTHPLACE (State or country): Tenn

PARENTS

10 NAME OF FATHER: Guy Richardson
11 BIRTHPLACE OF FATHER [State or country]: Tenn
12 MAIDEN NAME OF MOTHER: Emily Rusk
13 BIRTHPLACE OF MOTHER [State or country]: Tenn

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

15
Filed 192
Mrs H. McCasa
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 15 [Month] [Day] 1929 [Year]

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 1929, to Aug 15, 1929, that I last saw h.e.x alive on Aug 15, 1929, and that death occurred, on the date stated above, at 5 P. M

THE CAUSE OF DEATH* was as follows: Cerebro Spinal Meningitis

[Duration] yrs. mos. 9 ds.

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

Signed N B Ford M. D.
Nov 6, 1929 Address Gainesboro Tn

* 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 192

20 UNDERTAKER | ADDRESS