

WRITING 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. H  
 OR Gladdice  
 Village  
 OR  
 City (No. , St.; Ward)

STATE OF TENNESSEE  
 STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

24749

Registration District No. 444  
 Primary Registration District No. 3914

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

2 FULL NAME Roxie Mai Gairbreath Myers.

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Dec 26 1896  
 (Month) (Day) (Year)

7 AGE 53 yrs. 10 mos. 0 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION Housewife  
 (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) Jackson Co

10 NAME OF FATHER Hon. J. M. Gairbreath, decd.

11 BIRTHPLACE OF FATHER (State or country) Jackson Co Tenn

12 MAIDEN NAME OF MOTHER Sara Reeves

13 BIRTHPLACE OF MOTHER (State or country) Jackson Co Tenn

14 THE ABOVE IS TRUE TO THE REST OF MY KNOWLEDGE  
 [Informant] Estelle Gairbreath  
 [Address] Gainesboro Tenn

15 Filed #87 Oct 18 1929 Bury Ray.  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 26 1929  
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1929 to Oct 18 1929 that I last saw her alive on Oct 18 1929 and that death occurred, on the date stated above, at 2 A M

The CAUSE OF DEATH\* was as follows:  
Leucosarcoma of cervix  
46

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

Signed Chas. H. Robinson M. D.  
 191 \_\_\_\_\_ Address difficult

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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 Myer Cemetery DATE OF BURIAL Oct 27 1929

20 UNDERTAKER Ed. McNeill ADDRESS Cochran Rd. & Main