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

29723

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 Mrs Sallie ~~[illegible]~~ Leslie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Woman
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH (Month) (Day) (Year)

7 AGE: about 75 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: could not say
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): could not say thought N. C.

PARENTS

10 NAME OF FATHER: Do not know
11 BIRTHPLACE OF FATHER [State or country]: Do not know
12 MAIDEN NAME OF MOTHER: " "
13 BIRTHPLACE OF MOTHER [State or country]: " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] no Informant
[Address] Pauper

15
Filed Dec 26, 1929 H. E. Holleman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, That I attended deceased from ......192... to ......192..., that I last saw h... alive on ......192... and that death occurred, on the date stated above, at ...M

The CAUSE OF DEATH* was as follows:
no Dr.—do not know she died suddenly
204

[Duration] yrs. mos. ds.

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

Signed 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: Oct 16, 1929

20 UNDERTAKER: Williams Br
ADDRESS