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

29724

1 PLACE OF DEATH

County Jackson

Civil Dist. ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (No. ..... St.; ..... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Chas. Huff

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX: Male	4 COLOR OR RACE: white	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): single
6 DATE OF BIRTH: Feb (Month) 18 (Day) 1893 (Year)		
7 AGE: 36 yrs. 8 mos. 9 ds.	If LESS than 1 day, ... hrs. or ..... min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work: Farm Laborer		
(b) General nature of industry, business, or establishment in which employed (or employer): 012		
9 BIRTHPLACE (State or country): Jackson Co.		
PARENTS 10 NAME OF FATHER: James Huff		
11 BIRTHPLACE OF FATHER (State or country): Jackson Co.		
12 MAIDEN NAME OF MOTHER: Jennie Pharris		
13 BIRTHPLACE OF MOTHER (State or country): Jackson Co.		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed Dec 26 1929 H. S. Holleman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 27 (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 6 P M

The CAUSE OF DEATH* was as follows:

Epileptic Spasm

78

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Signed L. M. Fayne M. D.

..... 192..... Address Gainesboro Tenn

* 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
	10/28 1929
20 UNDERTAKER: J. M. Watts & Co	ADDRESS: Gainesboro