STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

29729

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. 5

OR Village Gramville

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 Mary Wade

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fml

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH ..... (Month) 1 (Day) 1922 (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country) Jackson County

PARENTS

10 NAME OF FATHER Littleton Wade

11 BIRTHPLACE OF FATHER [State or country] Jackson Co

12 MAIDEN NAME OF MOTHER Maggant Vinson

13 BIRTHPLACE OF MOTHER [State or country] Jackson Co ~~Maggant Wade~~

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] W C Williamson

[Address] Williamson Co

15

Filed Dec 6 1922 H S Hollaman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July [Month] 1 [Day] 1922 [Year]

17 I HEREBY CERTIFY, That I attended deceased from June 25 1922, to July 30, 1922, that I last saw h.. alive on July 30, 1922, and that death occurred, on the date stated above, at ..... M

The CAUSE OF DEATH* was as follows: Colitis 113

..... [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 Vinson Graveyard

DATE OF BURIAL July 2 1922

20 UNDERTAKER Williamson Bro

ADDRESS Gramville