STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

29736

CERTIFICATE OF DEATH

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. 6 The

OR

Village Granville

OR

City ..... (No. ....., ... St.; ..... Ward)

Registration District No. 44406

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 .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	Black	

6 DATE OF BIRTH Jan 30 1929
(Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. 18 ds.

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

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

9 BIRTHPLACE (State or country) Jackson Co.

PARENTS

10 NAME OF FATHER John F Myers

11 BIRTHPLACE OF FATHER [State or country] Jackson Co.

12 MAIDEN NAME OF MOTHER Ossie Lee Sadler

13 BIRTHPLACE OF MOTHER [State or country] ~~Jacks~~ Putnam Co

14 THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

[Informant] R C Hale

[Address] Granville

15

Filed Jan 11, 1929 W. S. Hollensead
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 12, 1929
[Month] [Day] [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:

due to Congenital Deformity 159c

[Duration] ..... yrs. ..... mos. ..... ds.

Contributory [SECONDARY] .....

[Duration] ..... yrs. ..... mos. ..... ds.

Signed L. W. Freeman M. D.

192... Address Granville 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 Feb 13, 1929

20 UNDERTAKER

ADDRESS