

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. 4  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

29738

Registration District No. 44406

File No. 9

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

2 FULL NAME

Walter Harris

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)

6 DATE OF BIRTH aug 6 1920  
 (Month) (Day) (Year)

7 AGE 9 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
 (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 John Harris

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Ellen Harris

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Picked up  
 [Address] \_\_\_\_\_

15 Filed \_\_\_\_\_ 192 \_\_\_\_\_  
Miss H. Maxton  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH aug 6 1929  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 192 \_\_\_\_\_ to \_\_\_\_\_ 192 \_\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 192 \_\_\_\_\_ and that death occurred, on the date stated above, at \_\_\_\_\_ M. The CAUSE OF DEATH\* was as follows: 2056

unknown  
 [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 Lynch Cemetery DATE OF BURIAL aug 7 1929

20 UNDERTAKER John Capeland ADDRESS Sainsboro