

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 Putnam  
Civil Dist. 11 or Village or City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)  
Registration District No. 725 File No. \_\_\_\_\_  
Primary Registration District No. 11 Registered No. \_\_\_\_\_

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

CERTIFICATE OF DEATH

2 FULL NAME Mary & Liza Carr

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Aug 29, 1847  
(Month) (Day) (Year)

7 AGE 69 yrs. 11 mos. 29 ds. IF LESS than 1 day, ----- hrs. or ----- min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House wife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Bill Kinard

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Jamie Kinard

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Billie Carr  
(Address) Silver Point Tenn

15 Filed Sept 8, 1917 W. B. Medley  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 23, 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 191\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
As Doctor in attendance

Heart Trouble  
.....(Duration)..... yrs. .... mos. .... ds.

Contributory (SECONDARY) \_\_\_\_\_  
.....(Duration)..... yrs. .... mos. .... ds.

(Signed) \_\_\_\_\_, M. D.  
....., 191\_\_\_\_ (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

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 Smellage Cemetery DATE OF BURIAL Aug 23, 1917

20 UNDERTAKER J. H. Medley ADDRESS Silver Point