

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 Rutledge  
 Civil Dist. First  
 OR  
 Village \_\_\_\_\_  
 OR  
 City Coopersville (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

STATE OF TENNESSEE  
 STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

166

Registration District No. 721  
 Primary Registration District No. 27201

File No. 90  
 Registered No. 10

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

2 FULL NAME Mrs Lillie B. Bobo

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 July 4  
(Month) (Day) (Year)

7 AGE 19 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION Housewife  
(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) Tennessee

10 NAME OF FATHER Ambros Speakman

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] J. F. Bobo  
 [Address] Coopersville

15 April 5 1922 L. E. Dyer  
Filed \_\_\_\_\_ 1922  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 14 1922  
(Month) [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from March 31 1922 to April 7 1922 that I last saw her alive on April 2 1922 and that death occurred, on the date stated above, 4 M

The CAUSE OF DEATH\* was as follows:  
Typhoid Fever  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory [SECONDARY] \_\_\_\_\_  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed J. H. Shipley M. D.  
 191 \_\_\_\_\_ Address Coopersville

\* 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 Livingston Ln DATE OF BURIAL Apr 10 1922

20 UNDERTAKER Jerrell White ADDRESS Coopersville