

WRITE PLAIN - 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. 17

or Village \_\_\_\_\_

or City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 47217

Primary Registration District No. 17

File No. 129

Registered No. 8-9

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

2 FULL NAME Dexter Waller

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Dec. 27, 1900  
(Month) (Day) (Year)

7 AGE 21 yrs. 6 mos. 11 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work. Farmer. 000  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tenn.

10 NAME OF FATHER William Waller

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Sarah Lewis

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Carlis Halley  
(Address) Bona

15 Filed July 9, 1922 W. J. Duke REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1922  
(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: 197  
Shot and killed instantly  
Homicide  
(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 Smelley Cem DATE OF BURIAL July 9, 1922  
20 UNDERTAKER W. Duke ADDRESS Bona