

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. 1st  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 721  
 Primary Registration District No. 47201

File No. 132

Registered No. 23

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

2 FULL NAME

Enson

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH July 16 1927  
 (Month) (Day) (Year)

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

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER W. W. Dow Enson

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Angie Francis Peck

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] From Birth Certificate  
 [Address] \_\_\_\_\_

15 Aug 4 1927 Lex Dow  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 12 1927  
 [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:

161a  
Premature Birth

Contributory [SECONDARY] \_\_\_\_\_

Signed \_\_\_\_\_ M. D.

\* 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 Edgewood Grave DATE OF BURIAL July 16 1927

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_