

MARGIN RESERVED FOR BINDING

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 **STATE OF TENNESSEE**
 County Rutherford
 Civil Dist. 20 Registration District No. 47220
 OR Village Baxter Primary Registration District No. _____ File No. 174
 OR City _____ (No. _____ St.; _____ Ward) Registered No. _____
 2 FULL NAME William Carl Morshe [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 6 DATE OF BIRTH July 14 1858
 7 AGE 64 yrs. 00 mos. 00 ds. If LESS than 1 day, _____ hrs. or _____ min.?
 8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer) 000
 9 BIRTHPLACE (State or country) K. Y.
 10 NAME OF FATHER John Morshe
 11 BIRTHPLACE OF FATHER (State or country) K. Y.
 12 MAIDEN NAME OF MOTHER Lizzie Bullington
 13 BIRTHPLACE OF MOTHER (State or country) _____
 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] W. Morshe
 [Address] Baxter
 15 Filed 1-9-23 A. R. Judd
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 17 1922
 [Month] [Day] [Year]
 17 I HEREBY CERTIFY, That I attended deceased from July 20 1912 to Sept 1 1922
 that I last saw him alive on Nov 3 1922
 and that death occurred, on the date stated above, at 11 P.M.
 The CAUSE OF DEATH* was as follows:
Gastric Ulcer
Cancer in Stomach
 [Duration] 2 yrs. 6 mos. 00 ds.
 Contributory [SECONDARY] _____ [Duration] _____ yrs. _____ mos. _____ ds.
 Signed J. Mac Wheeler M. D.
Nov 18 1922 Address Baxter
 * 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 _____ DATE OF BURIAL _____
 20 UNDERTAKER _____ ADDRESS _____