STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

2746

CERTIFICATE OF DEATH

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. 9

OR Village

OR City

Registration District No. 725

Primary Registration District No. 9

File No.

Registered No.

(No. , St.; Ward)

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

2 FULL NAME J V. Gambell

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: March (Month) 22 (Day), 1928 (Year)

7 AGE: yrs. 9 mos. 8 ds.

If LESS than 1 day, hrs. or min.?

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): Tenn

PARENTS

10 NAME OF FATHER: Johnie Gambell

11 BIRTHPLACE OF FATHER [State or country]: Tenn

12 MAIDEN NAME OF MOTHER: Martha Harris

13 BIRTHPLACE OF MOTHER [State or country]: Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Johnie Gambell

[Address] Buffalo Valley

15

Filed Jan 16, 1929 W. R. Medley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 14 (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from X, 192, to X, 192, that I last saw h alive on X, 192, and that death occurred, on the date stated above, at M

The CAUSE OF DEATH* was as follows: 2056

Influenza

[Duration] yrs. mos. ds.

Contributory [SECONDARY]

[Duration] yrs. mos. ds.

Signed no Dr. M. D.

, 192 Address

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. **State whether or not an operation was performed.**

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: Jan 15, 1929

20 UNDERTAKER

ADDRESS