

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

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

5979

Registration District No. 725  
 Primary Registration District No. 9

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

2 FULL NAME Dorothy Dean Williams

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Nov. 12, 1925  
(Month) (Day) (Year)

7 AGE 3 yrs. 8 mos. 5 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
 (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) Tenn.

10 NAME OF FATHER Gordell Williams

11 BIRTHPLACE OF FATHER (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Milburn Jones

13 BIRTHPLACE OF MOTHER (State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Minnie Denton  
 [Address] Buffalo Valley Tenn.

15 Filed Nov 9, 1929 W. R. Medley  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 20, 1929  
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929 to Feb 19, 1929, that I last saw her alive on Feb 19, 1929 and that death occurred, on the date stated above, at 11 a. m.  
 The CAUSE OF DEATH\* was as follows:

Broncho pneumonia

[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

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

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

Signed Samuel Denton M. D.

1929 Address Buffalo Valley Tenn.

\* 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 \_\_\_\_\_, 1929

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