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.

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

11290

1 PLACE OF DEATH

County Putnam

Civil Dist. 8

or Village

or City (No. , St.; Ward)

Registration District No. 47208

Primary Registration District No.

File No. 69

Registered No.

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

2 FULL NAME E. L. Stanley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mail

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X

6 DATE OF BIRTH 4 (Month) 14 (Day) 1851 (Year)

7 AGE 78 yrs. 0 mos. 6 ds.

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

8 OCCUPATION 000

(a) Trade, profession, or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ten

PARENTS

10 NAME OF FATHER John Stanley

11 BIRTHPLACE OF FATHER [State or country] Ten

12 MAIDEN NAME OF MOTHER Salie Kerby

13 BIRTHPLACE OF MOTHER [State or country] Ten

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] John Stanley Jr.

[Address] Silver Point Ten

15

Filed 4/20 1929 J. S. Herren REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 [Month] 20 [Day] 1929 [Year]

17 I HEREBY CERTIFY, That I attended deceased from 192 , to , 192 ,

that I last saw h alive on 192

and that death occurred, on the date stated above, at M

The CAUSE OF DEATH* was as follows:

Perallises 205b

[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 Pleasant View

DATE OF BURIAL 4/21 1929

20 UNDERTAKER

ADDRESS