STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

18344

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. 12

OR

Village

OR

City (No. , St.; Ward)

Registration District No. 724

Primary Registration District No. 724

File No.

Registered No. 10

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

2 FULL NAME Jim Keith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

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

6 DATE OF BIRTH: (Month) (Day) , 1 (Year)

7 AGE: 72 yrs. mos. 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

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER [State or country]: Unknown

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER [State or country]: "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Flonnie Keith

[Address] Baxter R#1, Tenn

15

Filed 7/9 1929 W. W. Cole REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 1 [Month] [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: attended by Dr. Saml Denton Buffalo Valley, Tenn

No Certificate filed

[Duration] yrs. mos. ds. 205 b

Contributory [SECONDARY]

[Duration] mos. ds.

Signed 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: Leftwich Cem DATE OF BURIAL: May 3 1929.

20 UNDERTAKER: None ADDRESS