

Form S. No. 4-40M.
 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. **14th**
 OR
 Village **SAND SPRINGS,**
 OR
 City (No. , St.; Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. **47214**
 Primary Registration District No. **14**

20725

File No. _____

Registered No. **31**

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

2 FULL NAME

****WILLIAM CARLSON MATHENEY,****

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Male** 4 COLOR OR RACE **WHITE** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Married,**
 (Write the word)

6 DATE OF BIRTH **MAY, 19, 1906.**
 (Month) (Day) (Year)

7 AGE **23** yrs. **2 (2)** mos. **13** ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION ***FARMER***
 (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer) **000**

9 BIRTHPLACE (State or country) **PUTNAM COUNTY**

10 NAME OF FATHER **ROBERT LEE MATHENEY,**

11 BIRTHPLACE OF FATHER [State or country] **TENNESSEE.**

12 MAIDEN NAME OF MOTHER **MARTHA ELIZABETH WELCH,**

13 BIRTHPLACE OF MOTHER [State or country] **TENNESSEE.**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] **Martha Elizabeth Matheny**
 [Address] **Monty Lee R.F. #1**

15 Filed **Aug 2, 1929** **Mrs. A. C. Killeffer**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **AUGUST, 1st, 1929-** 192
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from **July 1, 1929** to **Aug-1, 1929**, that I last saw him alive on **July 20, 1929** and that death occurred, on the date stated above, at **A. M. M.**
 The CAUSE OF DEATH* was as follows:

Pulmonary T.B. 31

[Duration] **2** yrs. _____ mos. _____ ds.
 Contributory **U. S. Service (Army)**
 [SECONDARY] [Duration] _____ yrs. _____ mos. _____ ds.

Signed **A. H. Woyers,** M. D.
Aug-1, 1929 Address **Monty Lee**

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE 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 **0** yrs. **9** mos. _____ ds. In the **20** yrs. _____ mos. _____ ds. of death _____ yrs. _____ mos. _____ ds. State **Pt BENING, Ga.**
 Where was disease contracted **Pt BENING, Ga.**
 if not at place of death? ***PUTNAM COUNTY***
 Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL **SAND SPRINGS, TENN.** DATE OF BURIAL **AUG. 2, 1929**

20 UNDERTAKER **Smith** ADDRESS **Monty Lee**