

Form S. No. 4-40M. WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY. 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. 14
OR
Village
OR
City Montgomery (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

20726

CERTIFICATE OF DEATH

Registration District No. 47214
Primary Registration District No. 14

File No. _____

Registered No. 32

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

2 FULL NAME George Franklin McDaniel

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 Nov 5 1885
(Month) (Day) (Year)

7 AGE 43 yrs. 9 mos. 5 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) Roan County

10 NAME OF FATHER John D. McDaniel

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Alice Roberts

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] George McDaniel

[Address] Montgomery

15 Filed Aug 11 1929 Mr. A. C. Kelleff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 10 1929
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from May 1 1929 to Aug 10 1929
that I last saw h. alive on April 10 1929

and that death occurred, on the date stated above, at 12:05 P
The CAUSE OF DEATH* was as follows: 31

Pulmonary tuberculosis
[Duration] _____ yrs. _____ mos. _____ ds.

Contributory [SECONDARY] _____
[Duration] _____ yrs. _____ mos. _____ ds.

Signed W. S. Grant M. D.
790 Montgomery 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 3 yrs. _____ mos. _____ ds. In the State 10 yrs. 5 mos. _____ ds.
Where was disease contracted, if not at place of death? Local
Former or usual residence Woodleaf Tenn

19 PLACE OF BURIAL OR REMOVAL Woodleaf DATE OF BURIAL Aug 11 1929

20 UNDERTAKER McKiff ADDRESS City