

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** 20730

**1 PLACE OF DEATH**  
 County Putnam  
 Civil Dist. 17  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
 Registration District No. 47217  
 Primary Registration District No. \_\_\_\_\_  
 File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** male    **4 COLOR OR RACE** white    **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** (Write the word) \_\_\_\_\_

**6 DATE OF BIRTH** Sept 13 1929  
 (Month) (Day) (Year)

**7 AGE** 3 yrs. 11 mos. 11 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** Smith Brown

**11 BIRTHPLACE OF FATHER** (State or country) Tenn

**12 MAIDEN NAME OF MOTHER** Margaret Waller

**13 BIRTHPLACE OF MOTHER** (State or country) Tenn

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 [Informant] Smith Brown  
 [Address] Bona Tenn

**15**  
 Filed Aug 19 1929 Wizell Bevil REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** August 13 1929  
 [Month] [Day] [Year]

**17 I HEREBY CERTIFY, That I attended deceased from** \_\_\_\_\_ 1929, to \_\_\_\_\_ 1929, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 1929 and that death occurred, on the date stated above, at \_\_\_\_\_ M. The CAUSE OF DEATH\* was as follows:  
Typhoid Fever  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Signed J. J. Smith M. D.  
 1929 Address Silverpoint

\* 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** Bona Tenn    **DATE OF BURIAL** Aug 13 1929

**20 UNDERTAKER** John Brown    **ADDRESS** Bona