

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

22910

## 1 PLACE OF DEATH

County PutnamCivil Dist. 1<sup>st</sup>or  
Village \_\_\_\_\_or  
City Cookeville R. 9 (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)Registration District No. 47207Primary Registration District No. 1

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

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

2 FULL NAME Amacie Mai Loftis

## PERSONAL AND STATISTICAL PARTICULARS

8 SEX 7 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)9 DATE OF BIRTH April 29, 1929  
(Month) (Day) (Year)7 AGE 4 yrs. 13 mos. 13 ds. IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?8 OCCUPATION  
(a) Trade, profession, or particular kind of work not any  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_9 BIRTHPLACE (State or country) Tennessee10 NAME OF FATHER William Loftis11 BIRTHPLACE OF FATHER (State or country) Tennessee12 MAIDEN NAME OF MOTHER Maggie13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Randle Loftis(Address) Cookeville R. 915 Filed Oct 8 1929 Paul Jennings REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 11, 1929  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
unknown no doctor attending 2056

\_\_\_\_\_. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_

\_\_\_\_\_. (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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 Double Springs DATE OF BURIAL Sept 12 192920 UNDERTAKER Randle Loftis ADDRESS Cookeville

MARGIN RESERVED FOR BINDING 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.