

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 Dis. 8

or
Village _____

or
City _____ (No. _____, St.; _____ Ward)

2 FULL NAME

Earl Pressley

STATE OF TENNESSEE

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

27597

File No. 2

Reg. No. _____

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ma 4 COLOR OR RACE W 5 Single, Married, Widowed, or divorced (Write the word)

6 DATE OF BIRTH 6 23 1929
(Month) (Day) (Year)

7 AGE _____ yrs. 4 mos. 28 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) Putnam co. Tenn.

10 NAME OF FATHER Charley Pressley

11 BIRTHPLACE OF FATHER (State or country) Putnam co. Tenn.

12 MAIDEN NAME OF MOTHER Lessa Herren

13 BIRTHPLACE OF MOTHER (State or country) Putnam co. Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charley Pressley

(Address) Silver Pointe

15 Filed 11/21 1929 J. S. Herren Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 21 1929
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attend deceased from _____ 19____, to _____ 19____, that I last saw h_____ alive on _____ 19____ and that death occurred, on the date stated above, at _____ M

The CAUSE OF DEATH* was as follows: 100d
Bronchial Pneumonia
fever

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
Signed R. H. Millis M. D.
_____ 19____ address Battle

*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 Judd Seminary DATE OF BURIAL 11/21 1929
20 UNDERTAKER _____ ADDRESS _____