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 27693

1 PLACE OF DEATH
County Putnam
Civil Dist. 13
OR Village Silver Point
OR City ..... (No. ..... St.; ..... Ward)

Registration District No. 47213
Primary Registration District No. .....
File No. 14
Registered No. 14
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Grace Frann Maxwell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	white	Single

6 DATE OF BIRTH: June (Month) 6 (Day), 1928 (Year)

7 AGE: 1 yrs. 5 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (State or country): Tenn

PARENTS

10 NAME OF FATHER: Houston Greene Maxwell
11 BIRTHPLACE OF FATHER [State or country]: Tenn
12 MAIDEN NAME OF MOTHER: Mary Ulzo Carr
13 BIRTHPLACE OF MOTHER [State or country]: Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] Mary Ulzo Maxwell
[Address] Silver Point Tenn

15
Filed Dec 11 1929 C. A. Hall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 24 (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20 1929, to Nov. 24, 1929, that I last saw h.. alive on Nov. 24, 1929 and that death occurred, on the date stated above, at 6 P. M

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

[Duration] ..... yrs. ..... mos. 5 ds.

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

Signed Sam'l Denton M. D.
....., 193.. Address Buffalo Valley Tenn

* 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: Silver Point — DATE OF BURIAL: Nov 25 1929

20 UNDERTAKER: none — ADDRESS