

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 Dist. 12  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

30421

CERTIFICATE OF DEATH

Registration District No. 724  
 Primary Registration District No. 724

File No. \_\_\_\_\_  
 Registered No. 16

2 FULL NAME

Mrs Lizzie Corwen

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
 (Write the word)  
 6 DATE OF BIRTH Feb 22 1863  
 (Month) (Day) (Year)

7 AGE 66 yrs. 7 mos. 14 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 County

10 NAME OF FATHER Mat Ferrell

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Louise McDonald

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] \_\_\_\_\_

[Address] \_\_\_\_\_

15 Filed 12/14 1929 W. Cole  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 6 1929  
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from June 6 1929 to Oct 6 1929 that I last saw her alive on Oct 6 1929 and that death occurred, on the date stated above, at 11 P.M  
 The CAUSE OF DEATH\* was as follows: 45

Pneumonia

9 [Duration] yrs. mos. ds.

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

Signed Dr. L. M. Freeman, M.D.  
 \_\_\_\_\_, 1929 Address Franklin

\* 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 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1929

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_