STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

30429

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. 17
OR
Village
OR
City (No. , St.; Ward)

Registration District No. 47217
Primary Registration District No. 17
File No.
Registered No. 7
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stiese Roberts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Mch. (Month) 2 (Day) 1864 (Year)

7 AGE: 65 yrs. 9 mos. ds.
If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Tenn

PARENTS

10 NAME OF FATHER: F. M. Roberts
11 BIRTHPLACE OF FATHER [State or country]: Tenn
12 MAIDEN NAME OF MOTHER: Sarah Richardson
13 BIRTHPLACE OF MOTHER [State or country]: Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant]

[Address]

15 Filed Dec 7, 1929 Mizell Duke REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 2 (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1929 to Dec 2, 1929, that I last saw ~~him~~ alive on Dec 2, 1929 and that death occurred, on the date stated above, at 10 P M

The CAUSE OF DEATH* was as follows: 10.a

Lobar Pneumonia

[Duration] yrs. mos. 9 ds.

Contributory [SECONDARY]

[Duration] yrs. mos. ds.

Signed R. H. Millis M. D.
Dec 7, 1929 Address Baxter 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: Boma Tenn
DATE OF BURIAL: Dec 4, 1929

20 UNDERTAKER: Amos Herron
ADDRESS: Boma Tenn