

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.

1 PLACE OF DEATH
 County White
 Civil Dist. 6
 OR
 Village Sparta #6
 OR
 City _____ (No. _____ St.; _____ Ward)
 Registration District No. 49406
 Primary Registration District No. _____
 File No. _____
 Registered No. 1
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME R Carrier Hudson

STATE OF TENNESSEE
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

4400

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

7 AGE about 69 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work on farm
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Tennessee

PARENTS

10 NAME OF FATHER Geo Hudson

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Sallie Hudson

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH Feb 3 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1927 to Feb 3, 1927 that I last saw him alive on July 2, 1924 and that death occurred, on the date stated above, at 10 M
 The CAUSE OF DEATH* was as follows: 756
Paralysis
 [Duration] _____ yrs. _____ mos. 17 ds.

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

Signed S D Davis M. D.
2/15, 1927 Address Sparta Tenn

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Oster D Ellis
 [Address] Sparta #6

15
 Filed _____ 1927 Mrs. C. K. Ward
 REGISTRAR

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 Greenwood Cemetery DATE OF BURIAL 2/5 1927

20 UNDERTAKER N B Hunter ADDRESS Sparta