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

9312

1 PLACE OF DEATH

County White

Civil Dist. 3

OR Village Sparta # 3

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

Registration District No. 963

Primary Registration District No. .....

File No. 18

Registered No. 18

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

2 FULL NAME Helen. Stewart

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH: November 6 I883 (Month) (Day) (Year)

7 AGE: 43 yrs. 5 mos. I3 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (State or country): Tennessee

PARENTS

10 NAME OF FATHER: Frank. Martin

11 BIRTHPLACE OF FATHER [State or country]: Tennessee

12 MAIDEN NAME OF MOTHER: Annie. Crowell

13 BIRTHPLACE OF MOTHER [State or country]: Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Mrs. Melonee. Lowrey

[Address] Sparta. Tenn #4

15 Filed April 192 Mrs J B Sparkman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April I9 I927 [Month] [Day] [Year] 192

17 I HEREBY CERTIFY, That I attended deceased from ..... 192 ..... to ..... 192 ....., that I last saw h..... alive on ..... 192 ....., and that death occurred, on the date stated above, at 3 P M

The CAUSE OF DEATH* was as follows:

Dropsy

No Doctor

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

Contributory [SECONDARY] .....

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

Signed ..... M. D.

..... 192 ..... Address .....

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

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: Hiland Cemetrey

DATE OF BURIAL: 4/20 I927 192

20 UNDERTAKER: H B Hunter

ADDRESS: Sparta