

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

11779

## 1 PLACE OF DEATH

County *White*Civil Dist. *1*OR  
Village *Sparta*OR  
City \_\_\_\_\_Registration District No. *941*Primary Registration District No. *1*

File No. \_\_\_\_\_

Registered No. *22*

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

2 FULL NAME *William Shelton*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_6 DATE OF BIRTH *Dec 23 1924*  
(Month) (Day) (Year)7 AGE *2 yrs. 5 mos. 2 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) *Tennessee*

10 NAME OF FATHER \_\_\_\_\_

11 BIRTHPLACE OF FATHER [State or country] \_\_\_\_\_

12 MAIDEN NAME OF MOTHER *Martha Shelton*13 BIRTHPLACE OF MOTHER [State or country] *Tennessee*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] *Jennie Shelton*[Address] *Sparta, Tenn.*

15

Filed *June 1, 1917* *A. G. Richardson*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 25 1917*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 191\_\_\_\_\_ to \_\_\_\_\_, 191\_\_\_\_\_

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_\_ and that death occurred, on the date stated above, at *4:30 AM*

The CAUSE OF DEATH\* was as follows:

*no section died*  
*address*  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory [SECONDARY] \_\_\_\_\_  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Signed \_\_\_\_\_ M. D.  
\_\_\_\_\_, 191\_\_\_\_\_ 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 *Highland County* DATE OF BURIAL *5/26 1917*20 UNDERTAKER *A. B. Hunt* ADDRESS *Sparta*

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.