

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

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

11784

County White

Civil Dist. 3

OR
Village Doyle.

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

Registration District No. 943

Primary Registration District No. _____

File No. 25

Registered No. 25

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

2 FULL NAME William Joe Helton

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 Sept 19 1925 (Month) (Day) (Year)

7 AGE 1 yrs. 7 mos. 25 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER Garfield Helton

11 BIRTHPLACE OF FATHER [State or country] Tennessee

12 MAIDEN NAME OF MOTHER Bettie Helton

13 BIRTHPLACE OF MOTHER [State or country] Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Gooch Helton

[Address] Doyle.

15

Filed June 7 1927 Miss B. Sparker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 14 1927 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 5-8- 1927 to 5-14- 1927, that I last saw him alive on 5-14- 1927 and that death occurred, on the date stated above, at _____ M

The CAUSE OF DEATH* was as follows Abscess on Brain

Contributory [SECONDARY] _____

Signed H. B. Aushan M. D.

5-14-1927 Address Doyle Tenn

* State the DISEASE CAUSING DEATH, or, in cases 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 Bethlehem Cemetery DATE OF BURIAL 5/15 1927

20 UNDERTAKER H. B. Aushan ADDRESS Doyle