

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. *5th*
 OR
 Village *Sparta*
 OR
 City *Tenn.* (No. _____ St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

14264

Registration District No. *943*

File No. *26*

Primary Registration District No. _____

Registered No. *26*

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

2 FULL NAME *John Wesley Swindell*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W.* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *Feb 11 1858*
 (Month) (Day) (Year)

7 AGE *69 yrs. 4 mos. 2 ds.* If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) *Tennessee*

10 NAME OF FATHER *Christopher Swindell*

11 BIRTHPLACE OF FATHER (State or country) *Tennessee*

12 MAIDEN NAME OF MOTHER *Eliza Nett*

13 BIRTHPLACE OF MOTHER (State or country) *Tennessee*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] *J. D. Swindell*
 [Address] *Sparta, R. R. #5*

15

Filed *June 18, 1927* *Mrs J B Sparrman* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *June 13 1927*
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from *May 25 1927* to *May 25 1927*, that I last saw him alive on *May 25 1927* and that death occurred, on the date stated above, at *9 AM*

The CAUSE OF DEATH* was as follows: *2056*
Don't know as I was ever called once when attempted drawing.

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

Signed *S. D. Davis* M. D.
 _____ 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. 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 *McPispha* DATE OF BURIAL *June 14, 1927*

20 UNDERTAKER *C. B. Clark* ADDRESS *Sparta Tenn*