

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

STATE OF TENNESSEE
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH **16882**

Registration District No. _____
 Primary Registration District No. 49406

File No. _____
 Registered No. 4

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

2 FULL NAME Edos Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 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 25 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. Farmer 000
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER [State or country] _____

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER [State or country] Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] Jeff Howard
 [Address] Sparta, T.C.

15 Filed _____ 192 _____
Mrs. S. K. Ward
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 16, 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____, 192 _____, to _____, 192 _____, that I last saw him alive on _____, 192 _____,

and that death occurred, on the date stated above, at _____ M
 The CAUSE OF DEATH* was as follows:

31
J. B. of Lungs
no. Dr. [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 New Hope DATE OF BURIAL April 17, 1927

20 UNDERTAKER H. B. Hunter ADDRESS Sparta Tenn