

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. 1st  
 OR  
 Village \_\_\_\_\_  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_, St. \_\_\_\_\_, Ward \_\_\_\_\_)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics

CERTIFICATE OF DEATH

19186

Registration District No. 941

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

Primary Registration District No. 1

Registered No. 40

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

2 FULL NAME Malinda Cummings

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
 (Write the word)

6 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

7 AGE about 75 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. I LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION Housewife  
 (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 Stanfield Broyles

11 BIRTHPLACE OF FATHER [State or country] Tennessee

12 MAIDEN NAME OF MOTHER Mamie Lowery

13 BIRTHPLACE OF MOTHER [State or country] Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Jim Cummings

[Address] Sparta, Tenn.

15 Filed 8/5 1917 A. S. Richardson  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 4 1917  
 [Month] [Day] [Year]

17 I HEREBY CERTIFY That I attended deceased from Aug 2 1917 to 4 1917, that I last saw him alive on Aug 4 1917 and that death occurred, on the date stated above, at 9 P. M.  
 The CAUSE OF DEATH\* was as follows: 74a

[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory [SECONDARY] \_\_\_\_\_ [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed W. J. Joseph M. D.  
8.4.1917 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 Lee Cemetery DATE OF BURIAL Aug 5 1917

20 UNDERTAKER B. Clark ADDRESS \_\_\_\_\_