

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. 13
 OR
 Village Clifty.
 OR
 City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

19194

Registration District No. 943
 Primary Registration District No. 13

File No. _____
 Registered No. 19

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

2 FULL NAME Seaborn. Seals

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 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 57 yrs. _____ mos. _____ 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) OOO

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER [State or country] ..

12 MAIDEN NAME OF MOTHER ..

13 BIRTHPLACE OF MOTHER [State or country] ..

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] D.W. Dodson
 [Address] Clifty Tenn

15 Filed _____ 1927 Mary L Cameron
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 23 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____ 1927 to _____ 1927
 that I last saw him alive on Aug 23, 1927
 and that death occurred, on the date stated above, at 2 PM

The CAUSE OF DEATH* was as follows: Apoplexy
7 Ad

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

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

Signed E. B. Clark M. D.
Spt 12 1927 Address Bon Air Tenn

*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 Brown Town Cemetery DATE OF BURIAL 8/24 1927

20 UNDERTAKER M. B. [unclear] ADDRESS [unclear]