

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. I3  
 OR  
 Village Clifty  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

1927

Registration District No. 945  
 Primary Registration District No. 13

File No. \_\_\_\_\_  
 Registered No. 14

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

2 FULL NAME Mayland Rector

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) 11111

6 DATE OF BIRTH April 3 1924  
 (Month) (Day) (Year)

7 AGE 3 yrs. 2 mos. 10 ds.  
 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION Miner, Son  
 (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 F. Merion Rector

11 BIRTHPLACE OF FATHER (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Effie Lewis

13 BIRTHPLACE OF MOTHER (State or country) Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Dock Dodson  
 [Address] Clifty, Tenn

15 Filed \_\_\_\_\_ 1927 Mary L Cameron REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927 to June 13, 1927, that I last saw him alive on June 1, 1927 and that death occurred, on the date stated above, at 2 P M

The CAUSE OF DEATH\* was as follows:  
whooping cough and pneumonia bronchial  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Signed E. B. Blank M. D.  
July 8 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 Clifty Cemetery DATE OF BURIAL 6/14 1927

20 UNDERTAKER H. B. Hunter ADDRESS Sparta