

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. 4th
 OR
 Village Walling
 OR
 City Tenn (No. _____, St.; _____ Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics
 CERTIFICATE OF DEATH

21361

Registration District No. 943

File No. 46

Primary Registration District No. _____

Registered No. 40

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

2 FULL NAME Mrs Armande Fisher

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH July 21 1897
(Month) (Day) (Year)

7 AGE 80 yrs. 2 mos. 8 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

9 BIRTHPLACE (State or country) Tenn

10 NAME OF FATHER Darius Clark

11 BIRTHPLACE OF FATHER (State or country) Tenn

12 MAIDEN NAME OF MOTHER Sallie Hudson

13 BIRTHPLACE OF MOTHER (State or country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] _____
 [Address] Walling Tenn

15 Filed Sept 20 1927 Mrs T. B. Sparker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 19 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 192 _____ to Sept 15 1927 that I last saw her alive on Sept 15 1927 and that death occurred, on the date stated above, at 10 P M
 The CAUSE OF DEATH* was as follows: 31

Pulmonary T. B.
 [Duration] _____ yrs. _____ mos. _____ ds.

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

Signed E. L. Morrison M. D.
Sept 20 1927 Address Rock Island

* 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 Fisher's Home DATE OF BURIAL Sept 20 1927

20 UNDERTAKER John W. High ADDRESS McMinnville Tenn