

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

23533

## CERTIFICATE OF DEATH

## 1 PLACE OF DEATH

County White

Civil Dist. #2

OR  
Village Sparta. #3OR  
City \_\_\_\_\_ (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)Registration District No. 943

Primary Registration District No. \_\_\_\_\_

File No. 45-

Registered No. \_\_\_\_\_

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

2 FULL NAME James. Monro. Passons

## 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 Aug 26 1851, 1 \_\_\_\_\_  
(Month) (Day) (Year)7 AGE 76 yrs. I mos. 17 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?8 OCCUPATION (a) Trade, profession, or particular kind of work On Farm  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Tennessee10 NAME OF FATHER William. Thomas. Passons11 BIRTHPLACE OF FATHER [State or country] Tennessee12 MAIDEN NAME OF MOTHER Celia. Grissom13 BIRTHPLACE OF MOTHER [State or country] Tennessee14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
[Informant] Thomas. Passons[Address] Cookeville. Tenn15 Filed Oct 27 1927 Mod B Sproun  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 15 1927  
[Month] [Day] [Year]17 I HEREBY CERTIFY, That I attended deceased from Jan 16 1925, to Oct 15, 1927, that I last saw him alive on Oct 15, 1927 and that death occurred, on the date stated above, at 10 20 AMThe CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhage  
& Valvular heart disease  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Contributory [SECONDARY]  
[Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Signed A. E. Gaines M. D.  
Oct 21, 1927 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.

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 Union. Cemetry DATE OF BURIAL 10/18 192720 UNDERTAKER N B Hunter ADDRESS SpartaMARGIN RESERVED FOR BINDING  
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.