

MARGIN 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.

1 PLACE OF DEATH  
 County White  
 Civil Dist. 1  
 OR  
 Village Sparta  
 OR  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
 Registration District No. 941 File No. \_\_\_\_\_  
 Primary Registration District No. 1 Registered No. 52  
 2 FULL NAME Nawthorne C Gray  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF TENNESSEE

STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH

25711

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 38 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
 8 OCCUPATION (a) Trade, profession, or particular kind of work Captain USA 876  
 (b) General nature of industry, business, or establishment in which employed (or employer) air corps  
 9 BIRTHPLACE (State or country) Richmond  
 10 NAME OF FATHER \_\_\_\_\_  
 11 BIRTHPLACE OF FATHER [State or country] VA  
 12 MAIDEN NAME OF MOTHER \_\_\_\_\_  
 13 BIRTHPLACE OF MOTHER [State or country] \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 4 1917  
 [Month] [Day] [Year]  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 191\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ M  
 The CAUSE OF DEATH\* was as follows: 188d  
Died while on  
aerial flight  
 [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory \_\_\_\_\_ [SECONDARY] \_\_\_\_\_ [Duration] \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Signed W. M. Johnson M. D.  
 \_\_\_\_\_ 191\_\_\_\_ Address \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 [Informant] Rt H H Couch  
 [Address] Belleville, Mo  
 15 Filed 11/6 1917 By A. L. Richards REGISTRAR

\* 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 Washington DC DATE OF BURIAL XXX 191X  
 20 UNDERTAKER Quaker Nurse Sparta ADDRESS \_\_\_\_\_