

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. H. C.
 OR
 Village Walling
 OR
 City Lebanon (No. St. Ward)

STATE OF TENNESSEE

STATE BOARD OF HEALTH
 Bureau of Vital Statistics 25718

CERTIFICATE OF DEATH Mooney

Registration District No. 943 File No. 147
 Primary Registration District No. Registered No. 47

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

2 FULL NAME

Clara Edward Ripshy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) single
 6 DATE OF BIRTH Jan 27 1926
 (Month) (Day) (Year)
 7 AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(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)

Georgia

PARENTS

10 NAME OF FATHER

Wes Ripshy

11 BIRTHPLACE OF FATHER (State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Mrs. Sulchins

13 BIRTHPLACE OF MOTHER (State or country)

Georgia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wes Ripshy
 [Address]

15

Filed Nov 17 1927 Mrs J. B. Sparhawk
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 17 1927
 [Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from 1926 to Nov 16 1927

that I last saw him alive on Nov 16 1927 and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Proseho Pneumonia 100 d

[Duration] yrs. mos. ds.

Contributory [SECONDARY]

[Duration] yrs. mos. ds.

Signed E. L. Worthington M. D.

11/17 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

DATE OF BURIAL

Spincy Hill 192

20 UNDERTAKER

ADDRESS

John W. Wright