

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. # 8

OR Village Sparta #7

OR City \_\_\_\_\_

(No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Nannie May Rice

STATE OF TENNESSEE

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

25721

Registration District No. 944

File No. 10

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

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

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH April 4 1927  
(Month) (Day) (Year)

7 AGE No 7 mos. 15 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER Gilbert Rice

11 BIRTHPLACE OF FATHER [State or country] Tennessee

12 MAIDEN NAME OF MOTHER Vallie McBride

13 BIRTHPLACE OF MOTHER [State or country] Tennessee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE [Informant] Gilbert Rice

[Address] Sparta #7

15 Filed Nov 23 1927 A. A. Bradley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 19 1927  
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 191\_\_\_\_\_ to \_\_\_\_\_ 191\_\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 191\_\_\_\_\_, and that death occurred, on the date stated above, at 4 AM. The CAUSE OF DEATH\* was as follows: 204

No Doctor Died Sudden

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

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

Signed \_\_\_\_\_ M. D.

\_\_\_\_\_ 191\_\_\_\_\_ Address \_\_\_\_\_

\* 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 Blk. Oak Cemetry DATE OF BURIAL 11/21 1927

20 UNDERTAKER B. Hunter ADDRESS Sparta