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BIRTH NO.

DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH
STATE OF TENNESSEE

DIVISION OF VITAL STATISTICS

DEATH NO. **58-06068**

1. NAME **William Cullie Nolen** 2. DATE OF DEATH **Mar. 27, 1958**
FIRST MIDDLE LAST MONTH DAY YEAR

3. COLOR OR RACE **White** 4. SEX **Male** 5. SINGLE, MARRIED, WIDOWED, DIVORCED (SPECIFY) **Married** 6. DATE MONTH DAY YEAR OF BIRTH **Aug. 30, 1883** 7. AGE (IN YEARS LAST BIRTHDAY) **74** IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MINS.

8. PLACE OF DEATH A. COUNTY **Carroll** B. CIVIL DISTRICT **16** 9. USUAL RESIDENCE OF DECEASED (Where Deceased Lived. If Institution, Residence Before Admission) A. STATE **Tenn.** B. COUNTY **Carroll** C. CIVIL DISTRICT **18**

C. CITY OR TOWN **Bruceston** D. LENGTH OF STAY IN THIS PLACE E. INSIDE CITY LIMITS? YES NO F. STREET ADDRESS (OR LOCATION) **Buena Vista** G. IS RESIDENCE ON A FARM? YES NO

E. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital or Institution, Give Street Address or Location) **Keeton Clinic** F. INSIDE CITY LIMITS? YES NO F. STREET ADDRESS (OR LOCATION) **Route # 1** G. IS RESIDENCE ON A FARM? YES NO

10A. USUAL OCCUPATION (Kind of Work Done During Most of Working Life, Even if Retired) **Farmer** 10B. KIND OF BUSINESS OR INDUSTRY **Own Farm** 11. SOCIAL SECURITY NUMBER **None** 12. WAS DECEASED EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES OF SERVICE YES, NO, OR UNKNOWN

13. BIRTHPLACE (State or Foreign Country) **Tennessee** 14. CITIZEN OF WHAT COUNTRY? **USA** 15. NAME OF HUSBAND OR WIFE **Angie Robison Nolen**

16. FATHER'S NAME **W. H. Nolen** 17. MOTHER'S MAIDEN NAME **Martha Jones** 18. INFORMANT ADDRESS **J. B. Nolen, Bemis, Tennessee**

19. CAUSE OF DEATH Enter only one cause per line for (A), (B), (C) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) **Cerebral Hemorrhage** 331

Conditions, if any, which gave rise to above cause (A); stating the underlying cause last } DUE TO (B) **Arteriosclerosis** 444

DUE TO (C) **Hypertension** PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I

20. WAS AUTOPSY PERFORMED? YES NO 21A. ACCIDENT SUICIDE HOMICIDE 21B. DESCRIBE HOW INJURY OCCURRED (Enter nature of Injury in Part I or Part II of Item 19)

21C. TIME OF INJURY: HOUR MO. DAY YR. A.M. P.M. 21D. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21E. PLACE OF INJURY (In or About Home, Farm, Factory, Street, Office Building, etc.) 21F. PLACE OF INJURY CITY, TOWN OR RURAL COUNTY STATE

22. I HEREBY CERTIFY THAT THE DECEASED DIED ON THE DATE AND FROM THE CAUSE STATED ABOVE SIGNATURE **R. T. Keeton** M.D. D.O. OTHER (SPECIFY) ADDRESS DATE **3-30-58**

23A. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23B. DATE OF BURIAL, CREMATION, OR REMOVAL **Mar. 28, 1958** 23C. NAME OF Cemetary or Crematory **Oak Grove** 23D. LOCATION CITY, TOWN OR COUNTY STATE **Carroll County, Tennessee**

24. FUNERAL DIRECTOR ADDRESS **Robert L. Dilday, Huntingdon, Tenn.** 25. REGISTRATION DIST. NO. **40916** 26. DATE SIGNED BY LOCAL REG. **4-4-58** 27. REGISTRAR'S SIGNATURE **Jean Essey Fields, Dep.**

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE - PUBLIC HEALTH SERVICE

THIS BECOMES A LEGAL RECORD WHEN PROPERLY EXECUTED AND WILL BE PLACED IN PERMANENT FILE.

WRITE PLAINLY WITH PERMANENT INK OR TYPEWRITER.

PHYSICIAN WHO ATTENDED DECEASED DURING LAST ILLNESS MUST GIVE WELL-DEFINED CAUSE OF DEATH AND SIGN MEDICAL CERTIFICATION. ANY PHYSICIAN, COUNTY HEALTH OFFICER OR CORONER EXECUTING CERTIFICATE MUST COMPLETE AND SIGN MEDICAL CERTIFICATION WITHIN 72 HOURS. POWER OF SIGNATURE CANNOT BE DELEGATED.

CAUSE OF DEATH. DO NOT WRITE IN THESE SPACES. DO NOT WRITE IN THESE SPACES. DO NOT WRITE IN THESE SPACES.

FUNERARY EXPENSES TO BE PAID BY THE DECEASED OR HIS ESTATE. IF THE DECEASED IS A MEMBER OF A FUNERAL HOME, THE FUNERAL HOME SHOULD BE NOTIFIED OF THE DEATH AS SOON AS POSSIBLE.

ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.