Form V. S. No. 4—40M. Jan. 25, 1927.

No. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

STATE OF TENNESSEE

STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

209

1 PLACE OF DEATH
County Carroll
Civil Dist. 14
OR Village
OR City (No. , St.; Ward)

Registration District No. 40914
Primary Registration District No. 14
File No.
Registered No. 6
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dr H. Parish

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): M.
6 DATE OF BIRTH: July 1 (Month) (Day) 1857 (Year)
7 AGE: 77 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9 BIRTHPLACE (State or country): Tenn.

PARENTS
10 NAME OF FATHER: John Parish
11 BIRTHPLACE OF FATHER [State or country]: Tenn
12 MAIDEN NAME OF MOTHER: Amant Hampton
13 BIRTHPLACE OF MOTHER [State or country]: Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
[Informant] John H. Parish
[Address]

15
Filed 1929
Mrs Jno Kellum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 8 (Day) 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1929 to Jan 8, 1929, that I last saw h alive on Jan 8 1929 and that death occurred, on the date stated above, at 3.40 PM

The CAUSE OF DEATH* was as follows:

Influenza 11 a

[Duration] yrs. mos. ds.

Contributory [SECONDARY] Bronchial Pneumonia

[Duration] yrs. mos. ds.

Signed C T Coy M. D.

Jan 8 1929 Address Westport

* 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: Mt Comfort
DATE OF BURIAL: Jan 9 1929
20 UNDERTAKER: R H Silday
ADDRESS