

## 1 PLACE OF DEATH

County CarrollCivil Dist. 24<sup>th</sup>or Village Westportor City Tenn (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

## STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

278

Registration District No. 40924

File No. \_\_\_\_\_

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

Registered No. 11

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

2 FULL NAME Joshua C Boyd

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)6 DATE OF BIRTH Jan 24, 1825  
(Month) (Day) (Year)7 AGE 93 yrs. 9 mos. 2 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer 800

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE (State or country)

North Carolina

## 10 NAME OF FATHER

John Boyd

## 11 BIRTHPLACE OF FATHER (State or country)

North Carolina

## 12 MAIDEN NAME OF MOTHER

Jula Butler

## 13 BIRTHPLACE OF MOTHER (State or country)

North Carolina

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Boyd(Address) Westport, Tenn

15

Filed Oct 27, 1918W. G. Sanders

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 26, 1918  
(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:

The family pronounced the cause of death as neuralgia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## Contributory (SECONDARY)

(Signed) W. G. Sanders Registrar, M. D.  
Oct 27, 1918. (Address) Westport, Tenn

\*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

Oak Grove Cemetery

## DATE OF BURIAL

Oct 27, 1918

## 20 UNDERTAKER

J. F. Merrick

## ADDRESS

Westport, Tenn

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.