

# STATE OF TENNESSEE

STATE BOARD OF HEALTH  
Bureau of Vital Statistics

## CERTIFICATE OF DEATH

141

### 1 PLACE OF DEATH

County Carroll

Civil Dist. ~~###~~ 12th

OR  
Village

OR  
City

Registration District No. ....

Primary Registration District No. ....

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

File No. ....

Registered No. ....

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

### 2 FULL NAME Littleton Azro Gooch

#### PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH May 10 1843  
(Month) (Day) (Year)

7 AGE 85 yrs. 7 mos. 29 ds. If LESS than 1 day, .... hrs. or .... min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Tennessee

10 NAME OF FATHER P Gooch

11 BIRTHPLACE OF FATHER (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Rust

13 BIRTHPLACE OF MOTHER (State or country) N. Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

[Informant] Mrs Tom Mitchell

[Address] Huntingdon, Tenn 255.RFD

15 Filed Jan 8 1928 Joe Laycock REGISTRAR

#### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8 1928  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 13/24 1927 192, to 1/8/28 192, that I last saw him alive on 1/8/28 192, and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH\* was as follows:  
My diagnosis was Atrophic degener- ation of liver due to repeated attacks of congestion of the liver.

[Duration] .... yrs. .... mos. 15 ds.

Contributory [SECONDARY] 124

[Duration] .... yrs. .... mos. .... ds.

Signed H. M. Gail M. D.

1/9 1928 Address Zuma Tenn

\* 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

Barr, s Springs. 1/9/28 192

20 UNDERTAKER ADDRESS

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.