

0305  
10  
0308  
BIRTH NO.

DEPARTMENT OF PUBLIC HEALTH

# CERTIFICATE OF DEATH

STATE OF TENNESSEE

DIVISION OF VITAL STATISTICS

DEATH NO. 56-24772

1. NAME *Mary Lou Wade* FIRST MIDDLE LAST 2. DATE OF DEATH *11/16/1956* MONTH DAY YEAR

3. COLOR OR RACE *W* 4. SEX *F* 5. SINGLE  MARRIED  WIDOWED  DIVORCED (SPECIFY) 6. DATE MONTH DAY YEAR OF BIRTH *June 26, 1880* 7. AGE (IN YEARS) LAST BIRTHDAY *76* IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MINS.

8. PLACE OF DEATH A. COUNTY *Benton* B. CIVIL DISTRICT *5<sup>th</sup>* 9. USUAL RESIDENCE OF DECEASED (Where Deceased Lived, If Institution, Residence Before Admission) A. STATE *Tenn* B. COUNTY *Benton* C. CIVIL DISTRICT *8<sup>th</sup>*

C. CITY OR TOWN *Cambden* D. LENGTH OF STAY IN THIS PLACE E. INSIDE CITY LIMITS? YES  NO  D. CITY OR TOWN *Big Sandy* F. STREET ADDRESS (OR LOCATION) *R#3* G. IS RESIDENCE ON A FARM? YES  NO

10A. USUAL OCCUPATION (Kind of Work Done During Most of Working Life, Even if Retired) *At Home* 10B. KIND OF BUSINESS OR INDUSTRY 11. SOCIAL SECURITY NUMBER 12. WAS DECEASED EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES OF SERVICE

13. BIRTHPLACE (State or Foreign Country) *Henry Co.* 14. CITIZEN OF WHAT COUNTRY? *U.S.A.* 15. NAME OF HUSBAND OR WIFE *R. L. Wade*

16. FATHER'S NAME *Ben Shring* 17. MOTHER'S MAIDEN NAME *Mary French* 18. INFORMANT ADDRESS *R. L. Wade, Big Sandy R#3.*

19. CAUSE OF DEATH Enter only one cause per line for (A), (B), (C) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (A) 20. WAS AUTOPSY PERFORMED? YES  NO  *795.4* *No Doctor attended* *Natural Death*

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 *J.P. Meator* M.D.  D.O.  OTHER (SPECIFY) ADDRESS *Camden Tenn* DATE *11/16/56*

23A. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* 23B. DATE OF BURIAL, CREMATION, OR REMOVAL *11/18/1956* 23C. NAME OF Cemetery or Crematory *Chapel Hill* 23D. LOCATION CITY, TOWN OR COUNTY STATE *Cambden, Tenn*

24. FUNERAL DIRECTOR ADDRESS *Camden Funeral Home, Camden, Tenn* 25. REGISTRATION DIST. NO. *40305* 26. DATE SIGNED BY LOCAL REG. *11-19-56* 27. REGISTRAR'S SIGNATURE *Indegene Johns*

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 CERTIFICATE WITHIN SEVENTY-TWO HOURS AFTER DEATH.

CAUTION: DO NOT DESTROY THIS CERTIFICATE WITHIN SEVENTY-TWO HOURS AFTER DEATH. THIS CERTIFICATE IS TO BE FILED WITH LOCAL REGISTRAR WITHIN SEVENTY-TWO HOURS AFTER DEATH AND PRIOR TO TRANSPORTATION BY COMMON CARRIER OR REMOVAL FROM STATE.

ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.