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DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH  
STATE OF TENNESSEE

DIVISION OF VITAL STATISTICS

DEATH NO. 59-21522

BIRTH NO. \_\_\_\_\_

1. NAME **Renna Lynch** 2. DATE OF DEATH **Aug. 1, 1959**  
FIRST MIDDLE LAST MONTH DAY YEAR3. COLOR OR RACE **W** 4. SEX **F** 5. SINGLE, MARRIED, WIDOWED, DIVORCED, (SPECIFY) **Widowed** 6. DATE MONTH DAY YEAR OF BIRTH **Aug. ,1874 84** 7. AGE (IN YEARS LAST BIRTHDAY) 8. IF UNDER 1 YR. MONTHS 9. IF UNDER 24 HRS. DAYS HOURS MINS.8. PLACE OF DEATH  
A. COUNTY **Benton** B. CIVIL DISTRICT **1** B. USUAL RESIDENCE OF DECEASED (Where Deceased Lived, If Institution, Residence Before Admission)  
A. STATE **Tenn.** B. COUNTY **Benton** C. CIVIL DISTRICT **1**C. CITY OR TOWN **Holladay** D. LENGTH OF STAY IN THIS PLACE **Life** D. CITY OR TOWN **Holladay** E. INSIDE CITY LIMITS? YES  NO E. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital or Institution, Give Street Address or Location) F. INSIDE CITY LIMITS? YES  NO  F. STREET ADDRESS (OR LOCATION) G. IS RESIDENCE ON A FARM? YES  NO 10A. USUAL OCCUPATION (Kind of Work Done During Most of Working Life, Even if Retired) **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 SERVICE13. BIRTHPLACE (State or Foreign Country) **Tennessee** 14. CITIZEN OF WHAT COUNTRY? 15. NAME OF HUSBAND OR WIFE **Allen Lynch**16. FATHER'S NAME **Unknown Earp** 17. MOTHER'S MAIDEN NAME **Unknown** 18. INFORMANT ADDRESS **Mrs. Nellie McDaniel, Camden, Tenn.**

## MEDICAL CERTIFICATION

19. CAUSE OF DEATH Enter only one cause per line for (A), (B), (C)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (A) **myocardial infarction H20.1**

Conditions, if any, which gave rise to above cause (A); stating the underlying cause last

DUE TO (B)

DUE TO (C)

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 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. REC'D BY STATE SEP 30 '59

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 STATE22. I HEREBY CERTIFY THAT THE DECEASED DIED ON THE DATE AND FROM THE CAUSE STATED ABOVE  
SIGNATURE **[Signature]** M. D. D. O. OTHER (SPECIFY) ADDRESS DATE **9/11/59**23A. BURIAL, CREMATION, REMOVAL (SPECIFY) **8-3-59 burial** 23B. DATE OF BURIAL, CREMATION, OR REMOVAL **8-3-59** 23C. NAME OF Cemetery or Crematory **Luper** 23D. LOCATION CITY, TOWN OR COUNTY STATE **Holladay, Tennessee**24. FUNERAL DIRECTOR ADDRESS **Stockdale-Malin F.H., Camden, Tenn.** 25. REGISTRATION DIST. NO. **40301** 26. DATE SIGNED BY LOCAL REG. **9-18-59** 27. REGISTRAR'S SIGNATURE **[Signature]**

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 EXECUTIVE (ARTIF). COMPLETE MEDICAL CERTIFICATION WITHIN 72 HOURS OF DEATH. SIGNATURE OF PHYSICIAN.

CAUSE OF DEATH. DO NOT WRITE IN THESE SPACES. ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.

FUNERARY DIRECTOR OR PERSON DISPOSING OF BODY, MUST FILE THIS CERTIFICATE WITH LOCAL REGISTRAR WITHIN 72 HOURS AFTER DEATH AND PRIOR TO TRANSPORTATION BY COMMON CARRIER OR REMOVAL FROM STATE.

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