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DEPARTMENT OF PUBLIC HEALTH

# CERTIFICATE OF DEATH

STATE OF TENNESSEE

DIVISION OF VITAL STATISTICS

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

DEATH NO. **65-008598**

1. NAME **Mrs. Alma Jones Barnes** 2. DATE OF DEATH **March 29, 1965**  
FIRST MIDDLE LAST MONTH DAY YEAR

3. COLOR OR RACE **W** 4. SEX **F** 5. SINGLE, MARRIED, WIDOWED, DIVORCED (SPECIFY) **Widowed** 6. DATE MONTH DAY YEAR OF BIRTH **6-13-1898** 7. AGE (IN YEARS LAST BIRTHDAY) **66** IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MINS.

8. PLACE OF DEATH A. COUNTY **Shelby** B. CIVIL DISTRICT **5th** 9. USUAL RESIDENCE OF DECEASED (Where Deceased Lived. If Institution, Residence Before Admission) A. STATE **Tenn** B. COUNTY **Shelby** C. CIVIL DISTRICT \_\_\_\_\_

C. CITY OR TOWN **Memphis** D. LENGTH OF STAY IN THIS PLACE \_\_\_\_\_ E. INSIDE CITY LIMITS? YES  NO

F. STREET ADDRESS (OR LOCATION) **2139 Nellie Road** G. IS RESIDENCE ON A FARM? YES  NO  E. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital or Institution, Give Street Address or Location) **St. Joseph Hospital** F. INSIDE CITY LIMITS? YES  NO

10A. USUAL OCCUPATION (Kind of Work Done During Most of Working Life, Even if Retired) **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY **At Home** 11. SOCIAL SECURITY NUMBER \_\_\_\_\_ 12. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN IF YES, GIVE WAR OR DATES OF SERVICE **No**

13. BIRTHPLACE (State or Foreign Country) **Lauderdale Co., Tenn** 14. CITIZEN OF WHAT COUNTRY? **U.S.A.** 15. NAME OF HUSBAND OR WIFE **James Patrick Barnes**

16. FATHER'S NAME **Robert Lee Jones** 17. MOTHER'S MAIDEN NAME **Alice Lacey** 18. INFORMANT ADDRESS **Lacey L. Barnes, 2139 Nellie Rd., City**

19. CAUSE OF DEATH Enter only one cause per line for (A), (B), (C)  
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (A) **Carcinoma of left breast with axillary pleural, bony and liver metastasis.** 20. WAS AUTOPSY PERFORMED? YES  NO   
DUE TO (B) \_\_\_\_\_ INTERVAL BETWEEN ONSET AND DEATH **2 years, 10 mos.**  
DUE TO (C) \_\_\_\_\_ **170**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (A) \_\_\_\_\_

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 **A. J. Grobmyer, Jr.** MED. EXAM.  D.O.  OTHER (SPECIFY)  ADDRESS **22 N. Pauline Memphis, Tennessee** DATE **4-3-65**

25A. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 25B. DATE OF BURIAL, CREMATION, OR REMOVAL **March 31, 1965** 25C. NAME OF Cemetery or Crematory **Memorial Park** 25D. LOCATION CITY, TOWN OR COUNTY STATE **Memphis Tenn.**

24. FUNERAL DIRECTOR ADDRESS **Cosmopolitan F.H. 1900 Union, Memphis** 25. REGISTRATION DIST. NO. **791** 26. DATE SIGNED BY LOCAL REG. **APR 5 - 1965** 27. REGISTRAR'S SIGNATURE **Lure Lacey**

Deputy

THIS BECOMES A LEGAL RECORD WHEN PROPERLY EXECUTED AND WILL BE PLACED IN PERMANENT FILE.

TYPE OR WRITE PLAINLY. ONE PERMANENT BLUE OR BLACK INK ACCEPTABLE. SIGNATURE MUST BE IN PERMANENT BLUE OR BLACK INK.

PHYSICIAN ATTENDED DURING MUST BE DEFINED DEATH MEDICAL OFFICER OF EXECUTIVE AND SIGNATURE IN DELEGATE



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

CAUSE OF DEATH. DO NOT GIVE MODE OF DYING SUCH AS HEART FAILURE, ASTHENIA, ETC. GIVE THE DISEASE, INJURY, OR COMPLICATION WHICH CAUSED DEATH.

FUNERAL DIRECTOR OR PERSON DISPOSING OF BODY, MUST FILE CERTIFICATE WITH LOCAL REGISTRAR WITHIN 72 HOURS AFTER DEATH AND FOR TO TRANSPORT BY COMMON CARRIER OR REMOVAL FROM STATE.

ALL ITEMS ARE TO BE COMPLETE AND ACCURATE.