MARGIN RESERVED FOR BINDING

V. S. No. 4

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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.

1 PLACE OF DEATH

County Sebastian

Township Upper

Inc. Town or City Ft. Smith

ARKANSAS STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH

Registration District No. 581

Primary Registration District No. 2345

924

File No.

Registered No.

(No. 423 North 7th St.; Ward)

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

2 FULL NAME Mrs. Carrie W. Horton

(a) Residence. No. 423 North 7th St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR or RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of E.S. Horton (Deceased)

6 DATE OF BIRTH November 28 1842
Month Day Year

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hawkins
(State or country) Tennessee

PARENTS

10 NAME OF FATHER Swimp Anderson

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER - -- Stamper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant
(Address)

15 Filed 10/26, 1929 Geo F Cottrell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 25, 1929
Month Day, Year

17 I HEREBY CERTIFY, That I attended deceased from June 21 1929 to Oct 26, 1929
that I last saw her alive on Aug 17—, 1929
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH was as follows:
State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

Senility - no other cause can be assigned —

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Gradual decline - Physical and Mental (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
What operation performed? no
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) E.K. Stevenson M. D.
10-26 1929 (Address) Ft Smith Ark

19. PLACE OF BURIAL, CREMATION, or REMOVAL: Springdale, Arkansas — DATE OF BURIAL: 10/27/1929

20 UNDERTAKER: Fentress Mortuary — ADDRESS: 23 N 8th

Burial or Transit Permit issued by ____ Date of issue ____