

FLORIDA STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

*Dr. C. C. Knight*

1. PLACE OF DEATH

County *Duval*  
Precinct \_\_\_\_\_  
(Write name, not number)  
or  
Inc. Town \_\_\_\_\_  
or  
City *Jay Fla.*

District No. \_\_\_\_\_  
Precinct No. \_\_\_\_\_  
City or Town No. \_\_\_\_\_  
No. *623 W. 1st*

State File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

2. FULL NAME *Oscar M. Hutson*

(a) Residence: No. *623 W. 1st* St., \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Colored* 5. Single, married, widowed or divorced (write the word) *married*

5a. If married, widowed or divorced HUSBAND of (or) WIFE of *Mary L. Hutson*

6. DATE OF BIRTH (month, day and year)

7. AGE Years *42* Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Prickerman*

9. Industry or business in which work was done, as silk mill, sawmill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation *25 yrs*

12. BIRTHPLACE (city or town) (State or country) *St. George Fl*

13. NAME *Warren Hutson*

14. BIRTHPLACE (city or town) (State or country) *Fla*

15. MAIDEN NAME *Hattie Mitchell*

16. BIRTHPLACE (city or town) (State or country) *Fla*

17. INFORMANT (Address) *Mary L. Hutson 623 W. 1st St*

18. BURIAL, CREMATION, OR REMOVAL Place *New York* Date \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (Address)

20. FILED \_\_\_\_\_ 19\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) *Sept 19 1920*

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, death is said to have occurred on the date stated above, at \_\_\_\_\_ p.m.

The principal cause of death and related causes of importance in order of onset were as follows:

*Cardiovascular renal syndrome* Date of onset \_\_\_\_\_

*from 3 PM Wed. Parlor, Family Lot, New York Richmond*

Contributory causes of importance not related to principal cause:

*Per. Mc Cormick Physician*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_ M.D.

(Address) \_\_\_\_\_

MARGIN RESERVED FOR BINDING

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.

