

FLORIDA STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County \_\_\_\_\_ District No. \_\_\_\_\_ State File No. \_\_\_\_\_  
 Precinct \_\_\_\_\_ Precinct No. \_\_\_\_\_  
(Write name, not number)  
 or  
 Inc. Town \_\_\_\_\_ City or Town No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 or  
 City \_\_\_\_\_ No. Folkston Ga. St., \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred 100 yrs. \_\_\_\_ mos. \_\_\_\_ ds. How long in U. S. if of foreign birth? \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

2. FULL NAME Julia Ann Jones

(a) Residence: No. Folkston Ga. St., \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE col 5. Single, married, widowed or divorced (write the word) \_\_\_\_\_

6a. If married, widowed or divorced HUSBAND of (or) WIFE of Frank Jones

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

7. AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min. 100

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

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 \_\_\_\_\_

12. BIRTHPLACE (city or town) Folkston Ga. (State or country) \_\_\_\_\_

MOTHER FATHER 13. NAME Ed Woodman

14. BIRTHPLACE (city or town) Folkston Ga. (State or country) \_\_\_\_\_

15. MAIDEN NAME Charlotte

16. BIRTHPLACE (city or town) Unknown (State or country) \_\_\_\_\_

17. INFORMANT Jannet Williams (Address) Folkston Ga.

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

19. UNDERTAKER James Samuel Hunter (Address) 121 W. State St.

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

21. DATE OF DEATH (month, day, and year) 9-21-1955

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 1240 m.

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

Date of onset

Contributory causes of importance not related to principal cause:

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.

