

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. County Hospital 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 _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

(a) Residence: No. 607 W 8th St., _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE Cobalt 5. Single, married, widowed or divorced single
 6a. If married, widowed or divorced HUSBAND of (or) WIFE of single

21. DATE OF DEATH (month, day, and year) Dec 21 19 34
 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 _____ m.

6. DATE OF BIRTH (month, day and year) _____
 7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. 72

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

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

Date of onset _____
 Contributory causes of importance not related to principal cause: _____

12. BIRTHPLACE (city or town) _____ (State or country) _____

MOTHER FATHER
 13. NAME _____
 14. BIRTHPLACE (city or town) _____ (State or country) _____
 15. MAIDEN NAME _____
 16. BIRTHPLACE (city or town) _____ (State or country) _____

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.

17. INFORMANT (Address) Angie S. Taylor
418 W. 7th

18. BURIAL, CREMATION, OR REMOVAL Place _____ Date _____ 19____

Manner of injury _____
 Nature of injury _____

19. UNDERTAKER (Address) _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

20. FILED _____ 19____ Local Registrar.

(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.

