

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

23852

1. PLACE OF DEATH _____
 County Madison
 Vol. Fol. _____ Registration District No. 1085
 Inc. Town South Christian Primary Registration District No. 2498
 City _____ (No. _____ St. _____ Ward _____)
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

File No. _____

Registered No. 19

2 FULL NAME Johm Wesley Blythe
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 18 yrs. 9 mos. 12 ds. New long in U.S. If of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____	4 COLOR OR RACE <u>Colored</u>	5 Single _____ Married <u>yes</u> Widowed _____ or Divorced _____ (Write the word)
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>Annie Blythe</u>		
6 DATE OF BIRTH <u>NOT KNOWN</u> (Month) _____ (Day) _____ (Year) _____		
7 AGE <u>about 74</u> yrs. _____ mos. _____ ds. _____		IF LESS than 1 day _____ yrs. _____ or _____ min?

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

9 BIRTHPLACE (city or town) Salazar
 (State or country) Smith County Tenn

PARENTS	10 NAME OF FATHER <u>Charles Gaines</u>
	11 BIRTHPLACE OF FATHER (city or town) <u>NOT KNOWN</u> (State or country) _____
	12 MOTHER NAME OF MOTHER <u>Marah Gaines</u>
	13 BIRTHPLACE OF MOTHER (city or town) <u>NOT KNOWN</u> (State or country) _____

14 (Informant) Safe Gann
 (Address) _____

15 Filed Oct 18, 1927 at Chattanooga
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 15 1927
 (Month) _____ (Day) _____ (Year) _____
 17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1927, to Oct 15, 1927, that I last saw him alive on Oct 11, 1927, and that death occurred on the date stated above at _____ M.
 THE CAUSE OF DEATH* was as follows:

Annie Blythe
(Sept 15 - Sept 10, 1927 - 1927)
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory abscess internal ear
 (Secondary) _____ (Duration) _____ yrs. 2 mos. _____ ds.

18 WHERE WAS DISEASE CONTRACTED
 If not at place of death? _____
 Did an operation precede death? _____ Date of _____
 Was there an autopsy? no
 What test confirmed diagnosis? none
 (Signed) Charles Woodburn, M. D.
Oct 12, 1927 (Address) Central City Ky

*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.)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Kushles Hill Oct 18
 20 UNDERTAKER E. J. Anderson ADDRESS Central City Ky

WRITE PLAINLY WITH INK—THIS IS A PERMANENT RECORD

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN 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.