DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

CERTIFICATE OF DEATH
GEORGIA DEPARTMENT OF PUBLIC HEALTH

State File No. ______
L. R. File No. 1

203 (1—50M—7-7-42

1. Place of Death
(a) County Paulding Militia Dist. No. California
(b) City or Town Dallas, Ga Rt 1.
(If Outside City or Town Limits, Write Rural)
(c) Name of Hosp. or Institution ______
(d) Length of Stay Before Death: Hosp. or Institution ______ In This Community ______

2. Usual Residence of Deceased
(a) State Georgia (b) County Paulding
(c) City or Town Dallas, Ga Rt 1
(If Outside City or Town Limits, Write Rural)
(d) R.F.D. and Box No. ______
(e) Citizen of Foreign Country? ______ (Yes or No) If Yes, Name Country ______
If Veteran Name War ______ Social Security Number ______

3. Full Name Mrs Antenette Holland

PERSONAL AND STATISTICAL PARTICULARS

4. Sex Female
5. Race White
6. Marital Status (circle) S. M. (W) D.
7. If Married or Widowed Give Name of Spouse ______
8. Age: Years 86 Months 3 Days 8 If less than 24 hrs. Hrs. ____ Min. ____
9. Date of Birth 10 22 1857 (Mo. Day Year) Birth Place Paulding Co. Ga
10. Usual Occupation Houskeeper
11. Industry or Business ______
Father
12. Name Sherman Bullock
13. Birthplace not known
Mother
14. Maiden Name Gann
15. Birth Place not known
16. Informants Own Signature A. J. Holland
17. Informants P. O. Address Dallas Ga
18. Burial, Cremation or Removal High Shoals (a) Date 2-1-44
19. P. O. Address of Place of Burial Dallas. Ga. Rt 3
20. Signature of Person Burying Body Lee Hdw. Co. J. T. Lee
21. P. O. Address of Undertaker Dallas, Ga Date Filed with L. R. 2/9-44
22. Registrar's Own Signature J. R. Lawrence

Please answer carefully all questions to avoid receiving queries for omitted information. Please give age, occupation and Social Security No. to assist in settling S. S. claims.

MEDICAL CERTIFICATION

23. Date of Death 1/31 1944 Time 2-30 P. M. (Hour : Minutes)
24. I hereby certify that I attended the deceased who died on the above date. I last saw her Alive on 1-31 1944
Primary Cause of Death Cerebral Hemorrhage Duration ______
(Please Underline the Cause to which This Death Should be Charged)
Contributory Causes Hypotension
(Including Any Pregnancy Within Three Months of Death)
Operation None
Date of Operation ______ Diagnosis: Clinical, Lab., X-Ray (Check) ______ Was Autopsy Performed: no
25. If death was due to external violence please answer the following questions:
(a) Accident, Suicide Homicide (Specify) ______ (b) Date of Occurrence ______
(c) Place of Accident ______ (City) ______ (County) ______ (State)
(d) Where: Home, Farm, Industry, Public Place ______ While at Work ______
(e) Means of Injury ______
26. Physician's Own Signature J. T. Anderson Date Signed 2/9-44
Physician's P. O. Address Dallas. Ga