1 PLACE OF DEATH

COUNTY Fulton

MILITIA DISTRICT Step

TOWN OR CITY ________ No. ________ ST. REG. DIST. NO. 512 REGISTERED NO. 16

(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER.)

GEORGIA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

FILE NO. FOR STATE REGISTRAR

BOV3. FORM 11

2 FULL NAME Rilla Ayers

RESIDENCE, CITY ________ No. ________ ST. ________ (IF NON-RESIDENT GIVE CITY OR TOWN AND STATE)

18 Length of residence in city or town where death occurred yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Negro

5 SINGLE, MARRIED, WIDOWED, DIVORCED (write the word) Married

5a IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rob Ayers

6 DATE OF BIRTH, (MO. DY. YR.)

7 AGE 65 yrs. ________ mos. 5 dys. IF LESS THAN 2 YEARS state if breast fed Yes ____ No ____ IF LESS than 1 day ____ hrs. ____ mins.

8 OCCUPATION (a) TRADE, PROFESSION OR PARTICULAR KIND OF WORK Farming (b) GENERAL NATURE OF INDUSTRY, BUSINESS OR ESTABLISHMENT IN WHICH EMPLOYED (OR EMPLOYER)

PARENTS

9 BIRTHPLACE (STATE OR COUNTRY) Hart Co

10 NAME OF FATHER Ayers

11 BIRTHPLACE OF FATHER (STATE OR COUNTRY) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (STATE OR COUNTRY) Unkown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(INFORMANT) E. H. Gholston

(ADDRESS) Comer Ga

15 FILED July 30 192__ S C Dalrymple LOCAL REGISTRAR

MEDICAL PARTICULARS

16 DATE OF DEATH June 19 192_

17 I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM June 15, 192_, TO June 19 192_

THAT I LAST SAW H__ ALIVE ON June 19 192_

AND THAT DEATH OCCURRED, ON THE DATE STATED ABOVE, AT 12 __ M. THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Brights Disease

(DURATION) ____ YRS. ____ MOS. ____ DYS.

CONTRIBUTORY (SECONDARY)

(DURATION) ____ YRS. ____ MOS. ____ DYS.

WHERE WAS DISEASE CONTRACTED, IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? ____ DATE OF ____

WAS THERE AN AUTOPSY? ____ WHAT TEST CONFIRMED DIAGNOSIS? No

(SIGNED) G. M. Pool M.D. M. D.

192__ (ADDRESS) Comer

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Deanbury Grove DATE June 20 192_

20 E. H. Gholston UNDERTAKER ADDRESS

Medical Particulars must be signed by Physician, Coroner or Registrar.