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

B.O.V.S. FORM 11

FILE NO. FOR STATE REGISTRAR

1 PLACE OF DEATH
COUNTY Franklin
MILITIA DISTRICT [illegible]
TOWN OR CITY ______ No. ______ ST. REG. DIST. NO. 812 REGISTERED NO. 6
(IF DEATH OCCURRED IN HOSPITAL OR INSTITUTION, GIVE ITS NAME INSTEAD OF STREET AND NUMBER.)

2 FULL NAME [illegible] Geo Howe

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 Male
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, DIVORCED (write the word) Single
5a IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6 DATE OF BIRTH (MO. DY. YR.) June 20 1927
7 AGE ______ yrs. ______ mos. ______ 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 Infant
(b) GENERAL NATURE OF INDUSTRY, BUSINESS OR ESTABLISHMENT IN WHICH EMPLOYED (OR EMPLOYER)

PARENTS
9 BIRTHPLACE (STATE OR COUNTRY) Ga
10 NAME OF FATHER Floyd Howe
11 BIRTHPLACE OF FATHER (STATE OR COUNTRY) Ga
12 MAIDEN NAME OF MOTHER Sallie Bryant
13 BIRTHPLACE OF MOTHER (STATE OR COUNTRY) Ga

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(INFORMANT) Floyd Howe
(ADDRESS) Carnesville

MEDICAL PARTICULARS

16 DATE OF DEATH June 20 1927

17 I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM ______ 192 ______, TO ______ 192 ______
THAT I LAST SAW H___ ALIVE ON ______ 192 ______
AND THAT DEATH OCCURRED, ON THE DATE STATED ABOVE, AT ______ M. THE CAUSE OF DEATH WAS AS FOLLOWS:
Still Born
(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?
(SIGNED) B. T. Smith M. D.
______ 192 ______ (ADDRESS) Carnesville

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Millers River
DATE 6/21 1927

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

(See Reverse Side for Additional Space.) Whether Accidental, Suicidal